**O.C.E.A.N. INC., KIDS/HEAD START PROGRAM**
**P.O. BOX 1029, 40 WASHINGTON STREET TOMS RIVER, NJ 08754**
**732-244-5333, ext 927**
**www.oceaninc.org**

# Application for Head Start Program 2018-2019

**Documentation required for eligibility:**

1. **Completed application**
   - **Child's Birth Certificate:** (*Vital Statistic Copy*)
   - Program services children ages 3 to 5; children need to be 3 years by October 1, 2018
   - Eligible children who turn 3 years after October 1, 2018 will be placed on a waiting list
2. **Proof of Income*** – Documentation must be from the past twelve months or calendar year. (Individual Income tax form1040, W-2 forms, pay stubs, written statement from employers specifying income, child support, or documentation showing current status of public assistance; TANF, SSI . ****For the Full Day: income from all adults 18 and older living in the household must be provided. Or a SS# to verify no income.***
3. Health Documentation: Current Physical, Immunizations, Dental Exam, Hemoglobin/Hematocrit & Lead Results. ****Flu shot is required during*** *(September through December of each school year).*
4. **Custody orders and or guardian ship / foster care paperwork must be submitted at time of Enrollment, to process the application.**

***When you submit your application in person, staff will conduct a brief interview to review your application. If you are unable to drop off your application you may mail it. We will call you for a phone interview.***

***You will be notified by letter after we received all the above –requested information and your child's eligibility has been determined.***

****This is a federally funded program, and there are income guidelines that determine eligibility***

**PROGRAM OPTIONS: Please review and select one for your child:**

**Full Day Program:** (school year - 44 weeks)
**8:00 am – 3:00 pm. - "Wrap around Services" are available, for a additional cost per week** 7:30 am to 8:00 am and 3:00 pm to 5:30 pm.****For parents whom are working full time and or full time students, documentation required***.
Full day program is offered at the following location:

____ Toms River Center

____ Requesting Wrap around Services

***Transportation is conditionally offered for half day sessions only, (some restrictions apply).**

**Modified Full Day:** (school year - 44 weeks)
**8:00 am – 3:00 pm.**
Modified program is offered at the following locations:

____ Barnegat Center
____ Berkeley Center
____ Brick Center
____ Manchester Center
____ Toms River Center

**Half Day Program:** (school year - 44 weeks).
Half day sessions - **AM session- 8:00am to 11:30 am or PM sessions - 12:30 to 4:00 pm,** Monday thru Thursday.
**No sessions on Friday.**
Half day program is offered at the following locations:

____ Brick Center
____ Toms River Center

____ *Requesting Transportation

***Current Employee or any relation to Ocean Inc. staff, Board or Policy council members:**

**Please specify**______________________________________________

**In accordance with Federal Law and U.S. department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. USDA is a equal opportunity provider and employer**

# Application for Head Start Program Year ____________________

| Child's **Legal** Name - **LAST** | **FIRST** | **Date of Birth:** ____________ Month/Day/Year |
|---|---|---|
| Address: | City: | Zip Code: |

**Child's Race:** Check one

__Am. Indian/Alaska Native
__Asian
__Black/ African American
__Native Hawaiian/Pacific Islander
__White
__Bi-Racial/ Multi-Racial

**Ethnicity:** Check one

Non Hispanic/Non Latino____________

Hispanic/Latino___________________

**Primary Language**: ________________

Proficient_______
Moderate______
Little__________
None_________

**Secondary Language**:_______________

Proficient_______
Moderate______
Little_________
None_________

**Child's Social Security #**:

_______/_______/_________

**Gender:** Male / Female

**Parental Status:**

☐ One Parent
☐ Two Parents
☐ Guardian
☐ Foster Parent

____________________________________

**Mother or Guardian Full Name**:

____________________________________

**Street Address (if different from child)** City Zip Code

Home Phone #: ( ) ____________________

Mother's Cell # : ( )____________________

Mother's work #: ( )____________________

Mother's Date of Birth: ____________________

Mother's primary language : ____________________

Custody: Yes / No

Lives with child: Yes / No

**Child's relationship to adult**;

☐ Natural/ Adopted/Step-child
☐ Grandchild
☐ Niece/ Nephew
☐ Foster Child
☐ Other

**Highest Level of education completed**:

9th grade/less_____ 10th grade_____ 11th grade_____ 12th grade_____

High School Graduate_______ GED_______ College/training_______

College degree______ Associates_______ Bachelor_________

Master's__________ Other__________________

____________________________________

**Father or Guardian Full Name:**

____________________________________

**Street Address (if different from child)** City Zip Code

Home Phone#: ( ) ____________________

Father's Cell #: ( )____________________

Father's Work # : ( )____________________

Father's Date of Birth: ____________________

Father's primary language: ____________________

Custody: Yes / No

Lives with child: Yes / No

**Child's relationship to adult**;

☐ Natural/ Adopted/Step-child
☐ Grandchild
☐ Niece/ Nephew
☐ Foster Child
☐ Other

**Highest Level of education completed**:

9th grade/less_____ 10th grade_____ 11th grade____ 12th grade______

High School Graduate_______ GED_______ College/training_______

College degree______ Associates_______ Bachelor_________

Master's__________ Other_________________

Do you receive CHS? Y / N

Do you receive SNAP (food stamps)? Y / N

**Do you have internet access? Y / N E-mail Address______________________________**

**Do receive TANF? Y / N SSI? Y / N WIC? Y / N WIC ID #______________________________**

**Military family? Y / N**

**Does your child have a disability (diagnosed by a doctor)? Y / N Does your child have an IEP? Y / N**

**Do you have concerns about your child in any of these areas below?**

**____Hearing ____Speech _____Asthma _____Seizures _____Other medical problem__________________**

**____Vision _____Allergies _____Diabetes _____Behavior/Emotional _____Other development concerns______________**

**Employment Status**: Parental / Guardian

- ☐ Full Time ( 35 + hours) Mother / Father / Guardian
- ☐ Full Time & Training Mother / Father / Guardian
- ☐ Part Time Mother / Father / Guardian
- ☐ Part Time/ Training Mother / Father / Guardian
- ☐ Retired/ Disabled Mother / Father / Guardian
- ☐ Training/School Mother / Father / Guardian
- ☐ Seasonally Employed Mother / Father / Guardian
- ☐ Unemployed Mother / Father / Guardian

**Do you have custody and / or Guardianship paper work: Yes / No** ( *office must have a copy for the safety of the child* )

Number In Family:[ ]In Home:[ ]Number of Children In Family: [ ] Birth to 3 Years Old [ ] 4 to 5 Years [ ]JR HIGH ( ) HIGH SCHOOL ( )

## FAMILY MEMBER INFORMATION

| First and Last Name of family members in home | Sex | How related to child | D. O. B |
|---|---|---|---|
| | M / F | | |
| | M / F | | |
| | M / F | | |
| | M / F | | |
| | M / F | | |

**Transportation Information for Half-Day Sessions Only:**

If your child will need to be picked up and/or dropped off at a different location please complete the following:

______________________________ ______________________________

Name of adult and/or program Relationship to child

____________________________________________________________

Address City State Zip Code

***Please indicate nearest cross street *:**

____________________________________________________________

**How did you hear about the program?**

_____Flyer ______Word of mouth ____Referred by agency (specify) ____________________

_____Radio ______TV ______Yellow pages ______Other (specify)____________________

_____ Internet Service/Google

**Other Factors That Contribute to Eligibility**

***(This confidential information is kept in the locked Enrollment files.)***

Please indicate if any of the following issues have affected your child and /or family the past twelve months or calendar year. The information provides us with a better understanding of the child and families' needs.

| | | | |
|---|---|---|---|
| | Currently receiving and/or have received services from DCP&P within the past year. | | Need affordable childcare to maintain employment/job training. |
| | Currently receiving and/or have received services from Board of Social Services (WIC, Special Response, Food Stamps, etc.). | | Child and /or parents (guardians) do not have medical insurance. |
| | Currently receiving and/or have received services through Early Intervention (IFSP). | | Parent(s) under the age of 21 years |
| | Emergency /crisis intervention (immediate need for food, clothing, or shelter). | | Homelessness (includes living with relatives or friends due to inability to rent or own home). |
| | Transportation issues | | Language Barriers (parent/ child). |
| | Unable to secure affordable housing (including rentals). | | Child is living with a Guardian. |
| | Domestic Violence | | Guardian is a Senior Citizen. |
| | Child abuse, neglect or child being exposed to Domestic Violence. | | Substance Abuse |
| | Parent/guardian and /or child health issues (physical, emotional, mental). | | Unable to secure jobs offering wages that maintain family's self-sufficiency. |
| | Parent /guardian are incarcerated and or deported. | | Other: |

**For Parent(s)/Guardian(s) completing application**

I ____________________________/____________________________, the biological parent(s) and/ or legal guardian(s) of (child's name) ______________________ certify that the information and documentation provided in this application is correct to the best of my/our knowledge.

______________________________________ __________
Signature of Parent/Guardian Date

______________________________________ __________
Signature of Parent/Guardian Date

**Please drop off or mail completed application to:**
Enrollment Office
P.O. Box 1029, 40 Washington Street
Toms River, NJ 08754
www.oceaninc.org ***Questions regarding application process: 732-244-5333, Ext. 927***

****To be completed by: OCEAN, INC. STAFF***

***Eligibility Interview conducted***

☐ **In- person**
☐ **Telephone**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

X ________________________________________________

OCEAN Inc. Kids /Head Start
P.O. Box 1029- 40 Washington Street
Toms River, NJ 08754

## MUST READ- IMPORTANT!!

**The following Health Documentation is Required for all children to attend the Head Start Program.** If we are not in receipt of the following documentation in the mandated time your child will be place on a waiting list. Please remember it is best to have all documentation completed at time of enrollment.

**Requirements at time of Enrollment:**

- **Current Physical Exam: The physician must complete the Universal Child Health Record attached. Physical must be completed yearly.**
- **Immunization Record with Doctor's stamp: All children are required /mandated by the State of NJ to be vaccinated. This includes an Influenza Vaccine, to be given between September 1 and December 31 (During Flu season of each school year).**
- **Hemoglobin/Hematocrit blood test date and results:** Done at age 12 months ( May use "Wic Form" attached if enrolled in WIC Program). Physician's office may already have on record.
- **Lead level blood test date and results.** Usually done at 12 and 24 months of age. Physician's office may already have on record.

**Required within 90 Days of Enrollment:**

- **Dental Exam: The attached dental form must be completed by your child's dentist. Dental Exams must be complete every 6 months.**

**Required within 45 Days of Enrollment:**

- **Vision and Hearing: May be completed by medical provider or Head Start Health Services with sign consent.**

***Additional testing such as a Mantoux may be required if child is born outside the U.S.**

*OCEAN, Inc.Helping People, Changing Lives.*
*www.oceaninc.org*
*40Washington Street*
*P.O. Box 1029*
*Toms River, NJ 08754*

**HIPAA**
**(*Health Insurance Portability and Accountability Act*)**
**AUTHORIZATION FOR USE, RECEIVE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION, CHILD EDUCATION RECORDS, AND FAMILY INFORMATION**

I, ______________________________ (print name of individual), hereby authorize O.C.E.A.N. Inc., Head Start to use, receive and/or disclose my child's individually identifiable health information, education records and or other records pertaining to my child, or myself as specified below.

I authorize O.C.E.A.N. Inc., to receive, disclose or use the following information to provide educational services:

Specific information to be disclosed, received and/or released (please specify):

| Records pertaining to: | | |
|---|---|---|
| Child's Name: | DOB: | |
| • Child Physical Exam/Well Visit Record | • Child Dental Exam Record | • Child Immunization Record |
| • Screening/Assessment Results | • Child Evaluations/IFSP/IEP Records | • Child Permanent Record |
| • Child Progress Reports | • Child Birth Record | • Food Stamp/TANF Report |
| • WIC Anemia Screening Results | • Specialist (if applicable) | • Treatment Plan |
| • School-Based Health Care Plan | • Asthma/Allergy Action Plan | • Other |

Reason for disclosure/Receiving and use of information: ______________________________

Prohibition on re-disclosure: This information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR) Part 2 prohibits the recipient of this information from making any further disclosure of this information except with the specific written consent of the person to whom it pertains or the legal guardian of the minor child to whom the information pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

Revocation: I understand that I may revoke this authorization at any time by notifying O.C.E.A.N. Inc., Head Start in writing. I understand that if I revoke this authorization, it will not affect any actions O.C.E.A.N. Inc., Head Start took while the authorization was in place.

Expiration date: This authorization will expire ____________9/3/2019__________

Consent for Disclosure/Receiving: I recognize that the information disclosed/received may contain information that is protected by Federal and State law, and I specifically consent to disclosure/receiving of such information. O.C.E.A.N. Inc., Head Start will not make authorization a condition for participation in the Head Start program.

| Name of Client/Parent/Legal Guardian: | Date: |
|---|---|
| Signature of Client/Parent/Legal Guardian: | Date: |
| Name of Staff Member: | Date: |
| Signature of Staff Member: | |

Authorization Received/Sent by: ______________________ Records Copied and Sent/Received: ____/____/____

# UNIVERSAL CHILD HEALTH RECORD

*Endorsed by:* *American Academy of Pediatrics, New Jersey Chapter*
*New Jersey Academy of Family Physicians*
*New Jersey Department of Health*

## SECTION I - TO BE COMPLETED BY PARENT(S)

| Child's Name *(Last)* | *(First)* | Gender ☐ Male ☐ Female | Date of Birth / / |
|---|---|---|---|

| Does Child Have Health Insurance? ☐Yes ☐No | If Yes, Name of Child's Health Insurance Carrier |
|---|---|

| Parent/Guardian Name | Home Telephone Number | Work Telephone/Cell Phone Number |
|---|---|---|
| Parent/Guardian Name | Home Telephone Number | Work Telephone/Cell Phone Number |

***I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.***

| Signature/Date | This form may be released to WIC. ☐Yes ☐No |
|---|---|

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

| Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No |
|---|---|

| Abnormalities Noted: | Weight *(must be taken within 30 days for WIC)* | |
|---|---|---|
| | Height *(must be taken within 30 days for WIC)* | |
| | Head Circumference *(if <2 Years)* | |
| | Blood Pressure *(if ≥3 Years)* | |

| IMMUNIZATIONS | ☐ Immunization Record Attached<br>☐ Date Next Immunization Due: |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ Special Care Plan Attached | Comments |

### PREVENTIVE HEALTH SCREENINGS

| Type Screening | Date Performed | Record Value | Type Screening | Date Performed | Note if Abnormal |
|---|---|---|---|---|---|
| Hgb/Hct | | | Hearing | | |
| Lead: ☐ Capillary ☐ Venous | | | Vision | | |
| TB (mm of Induration) | | | Dental | | |
| Other: | | | Developmental | | |
| Other: | | | Scoliosis | | |

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

| Name of Health Care Provider (Print) | Health Care Provider Stamp: |
|---|---|
| Signature/Date | |

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

O.C.E.A.N., Inc. Kids/Head Start
PO. Box 1029 - 40 Washington Street
Toms River, NJ. 08754

CHILD'S NAME: ______________________ SEX:________ BIRTHDATE: ____________ CENTER ____________

ADDRESS: ______________________________ PHONE: ( ) ____________

1) IS THE CHILD NOW RECEIVING:
Topical Fluoride Application? No___Unknown___Yes___
Fluiridated Water? No___Unknown___Yes___
Fluoride Supplement Diet? No___Unknown___Yes___
(Tablets___Liquid___)

2) Does the child have any trouble with teeth, gums, or mouth that the parent knows about?

**3) Oral Conditions before treatment:**
Missing Decayed Filled

UPPER RIGHT LEFT LOWER LINGUAL
A B C D E F G H I J 3 14 30 19 T K S L R M Q P O N

**4) Examination and Treatment Record (list recommended services in order)**

| Tooth # or Letter | Surfaces | Description of Work | Treatment Approved | Date Service Performed |
|---|---|---|---|---|
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5) DENTAL NEEDS (check all that apply)
____ Treatment (restoration, pulp therapy, extraction)
____ Cleaning
____ Fluoride
____ Within Normal Limits
____ Other (explain) ______________________ (___Swollen ___Bleeds Easily___ Infected)

6) ORAL HEALTH SUMMARY:
Treatment ____ IS ____ IS NOT complete. Explain: ______________________

___ Routine recall visits
___ Oral Hygiene Instruction for Home — Explain: ____________
___ Dietary Problems — Explain: ____________
___ Developmental Problems — Explain: ____________
___ Harmful oral habits — Explain: ____________
___ Fluoride Supplement needed

**DATE OF EXAM**____________

**PROVIDER'S STAMP**
**NAME &** ______________ **SIGNATURE:**______________ **DATE:** ____________
**ADDRESS:** ______________ **PHONE:**____________

0411

Daniel E. Regenye, M.H.A., Lic. H.O.
Public Health Coordinator

Email: Dregenye@ochd.org

**OCEAN COUNTY HEALTH DEPARTMENT**
**P.O. Box 2191**
**Toms River, NJ 08754-2191**
**(732) 341-9700 ext. 7201**
**Fax: (732) 831-6495**

## New Jersey State WIC Program
## Request for Review/Release of Information

I hereby request from the ______________________________ WIC Program

to have released information concerning:

Name ______________________________ ID# ____________________

______________________________ ____________________

______________________________ ____________________

Nature of Information (check one):

_____ Eligibility File

_____ Documents concerning matter under appeal

_____ Fair hearing official record

By signing below I acknowledge:

1. Receipt of the materials requested
2. That I will not hold the WIC Program responsible for a breach in confidentiality should I lose or misplace these materials, or if I share them with others.

Signed______________________________ Date____________________
(Authorized Representative/Participant)

Witness______________________________

(Over)