Confederated Tribes of Siletz Indians
P.O. Box 549 Siletz, Oregon 97380
(541) 444-2532 • 1-800-922-1399 • FAX: (541) 444-2307

Dear Family,

Thank you for your interest in our Head Start Program. We are currently accepting applications for the **2017 – 2018** school- year. Our Head Start has **classrooms in Siletz, Salem, Portland and Lincoln City.** You do not have to be Native American to attend our program. We will notify families in **May 2017** if they were selected. Please turn in your application as soon as possible.

New enrollment requirements from the Office of Head Start mandate that we must conduct either a face-to-face or telephone interview to verify information on your child's application. We will call you to verify the information on the application. If we don't reach you we will leave a detailed message and ask that you call us back. **Call us back** as soon as possible. We cannot enroll any child until we complete this verification process.

Our programs offers bus transportation for all children enrolled in our program. However, due to considerations such as distance, time and appropriate practice, **you could be asked to self-transport should it be necessary to maintain a safe, efficient bus route.**

Please return the following documents with your completed application:

1. **Documentation of family income from all sources**, it may consist of: **a.** Current payroll check stub(s) for one month; **b.** TANF award statement or copy of current check; **c.** Foster care award statement or copy of check; **d.** Annual income tax or W-2 statement(s); **e.** Self employment or business statement; **f.** Social Security or SSI award statement; **g.** Unemployment benefit statement or copy of check. **h.** Zero Income Statement is included on the back of the application form **(Income Verification is Mandatory for all families and your child's application cannot be processed without it)**

2. If applicable, **documentation of child's enrollment or descendency in a federally recognized Indian Tribe**, it may consist of: **a.** Copy of Tribal I.D; **b.** Certificate of Indian Blood (CIB); **c.** For descendency copy of Tribal ID, CIB or other documentation that verifies enrollment of parent, grandparent, great-grandparent, etc. and birth records which show lineage back to child. **(Indian Preference cannot be given unless verified)**

3. If applicable, **documentation of child's diagnosed disability**, it may consist of: **a.** Copy of Individual Family Service Plan (IFSP); **b.** Letter or statement from qualifying agency stating your child's meets this definition; **c.** Letter or note from physician or other qualified health provider. **(Disability preference cannot be given unless verified)**

4. **Copy of Child's Immunization Record**. (Note: This is required before any child could attend class.)

If you have any questions please feel free to contact me by telephone at 1-800-922-1399 and ask for Head Start or 541-444-2450.

In Partnership with Children and Families,

DeAnn Brown, Director
Siletz Tribal Head Start

SILETZ TRIBAL HEAD START **COMMUNITY NEEDS ASSESSMENT 2017-2018**

Siletz Tribal Head Start is conducting a survey to identify needs that exist in our community. This information is used to determine what programs and services would be relevant for Head Start to offer in the future. Your assistance will help ensure that our program meets your needs. Your input and support is valuable. Thanks!

Check One (Optional): _____ Native American _____ Other_____

Which County do you live in (circle one): Lincoln Marion Multnomah Other_____

Family Data: Single Parent Household? ___NO ___YES Foster Parent/Grandparent? ___ NO ___YES

Total Number of Household Memebers: _____ Total Number of Children in Family: _____

Age(s) of parents: _____ Are any of your children disabled? __NO ___YES

Economic Information:

Parent(s) Employed: ___Full-time ___Part-time ___Not Employed ___In Training/School

Gross Monthly Income: _____ Highest Grade Completed by Parent: _____

Does Family Receive: ___TANF ___Food Stamps ___SSI ___GA ___OHP ___WIC

Do you: Own or Rent your home? _____ Monthly Rent/House Payment _____

Do you receive Section 8 or other housing assistance? ___No ___Yes

Transportation Do you have reliable transportation? ___NO ___YES

Do you have access to public transporation? ___ NO ___YES

Childcare: Do you have children in childcare now? ___NO ___YES How Many Hours Per Week?_____

How much do you pay for care? _____Hr/Mo. Is it easy to find & use child care services? ___NO ___YES

How would you rate your childcare? ___Poor ___Fair ___Good ___ Great

Please select the 4 issues that are most important to you and rank them 1st highest to 4th lowest in priority

____Employment ____Education ____Preschool/Head Start ____Recreation ____Housing ____Literacy

____Health Care ____Dental Care ____Nutrition ____Child Care ____Parenting ____Cultural Activities

____Alcohol & Drug Awareness ____Obesity ____Other _____

Should Head Start Services be (please circle one for each of the 3 questions):

1. Full-day or Part-day 2. Full-Year or Part-Year 3. Classroom or Home Based

Should Head Start Services serve children ages 0 – 3 years? Yes No

Any other comments? _____

SILETZ TRIBAL HEAD START ENROLLMENT APPLICATION

RETURN THIS APPLICATION TO: Siletz Tribal Head Start, PO Box 549, Siletz, OR 97380 or Fax to 541-444-2307
For more information call 1-800-922-1399 ext. 1376 or (541) 444-8376.

CHILD'S NAME _____ **Returning Student:** _____**Yes** _____**No**

Child's Sex: M F **Child's Date of Birth:** ____/____/____ **AGE NOW** _____

Does child have a **disability or special need?** No ____ Yes _____Explain: _____
(Please attach verification)

Is child **descendent/member of a federally recognized Indian Tribe**? No ___ **Yes** ____Tribe/Roll #_____
(Please attach verification)

Are You Homeless? No____ **Yes**____ (Homeless means individuals who lack a fixed, regular, and adequate nighttime residence; For example, living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations, or are awaiting foster care placement.)

PARENT/GUARDIAN NAME(S):

1. _____Birthdate _____

2. _____ Birthdate _____

Street Address: _____ City: _____ Zip Code: _____

Mailing Address: _____ City:_____ Zip Code: _____

Telephone #'s: Home _____ Work _____ Message _____

Bus Pick-up and drop-off address if different from above:_____

A preference for enrollment can be given to families which face any of the following conditions: single parent household, parents separated or divorced, child is a victim of abuse or neglect or child suffers a non-handicapping medical condition, foster child,sibling who attended the program, parent participated in the Siletz Tribal Maternal Home Visiting Program. If your family meets any criteria and you want to claim that preference, **please list the qualifying condition(s) here:**

_____

LIST ALL OTHER HOUSEHOLD MEMBERS BY NAME and DATE Of Birth : Total # Household members_____
Please add additional families members to the back of this application

1._____ 2._____

3. _____ 4._____

FINANCIAL STATEMENT (YOU MUST attach verification of these benefits.) Check all that apply:
____ Employed ____ Unemployment ____ General Assistance ____ Child Support ____ TANF ____ Veteran's Benefits
_____ Social Security _____Disability _____College Grants/Scholarships ____ Other, explain _____

TOTAL GROSS MONTHLY INCOME $_____ **(YOU MUST attach verification)**

With my signature I certify that the above information is complete and accurate:

Signature:_____Date: _____

(OVER)

Please list additional family members here:

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

11. _____ 12. _____

IF you are claiming Zero Income, please complete the section below:

Siletz Tribal Head Start
Zero Income Statement

_____
Date

To Whom It May Concern:

This statement is to verify that I receive no income from any source, including:

Employment Income
Child Support, Alimony or Regular Contributions from persons not living in the household
Financial Aid
Public Assistance (TANF) (General Assistance)
Dividends, income from estates or trust, rental income
Interest on savings of other interest investments
Veterans' payments
Unemployment or Worker's Compensation Benefits
Private Pensions or Government Pensions
Annuities
Social Security Benefits, Supplemental Security Income (SSI)
Disability Benefits
Other Cash Income
Per Capita

_____
Signature

This form must be completed and signed by a physician.
Please do not defer any tests.

Siletz Tribal Head Start Health Summary

Return this form to : Siletz Tribal Head Start, PO Box 549, Siletz, OR, 97380.

Child's Name: _____ Sex: M F DOB: _____

Parent/Guardian Name: _____ Phone Number: _____

Medical Personnel Only	Medical Personnel Only
Hct or Hgb completed in past 12 months? ☐ **No scheduled for** _____ ☐ **Yes: Date** _____ **Results** _____ **Any follow-up?** _____	**Has child had a Lead Screen at 12 and 24 months** ☐ **No scheduled for** _____ ☐ **Yes: Date** _____ **Results** _____ **Any follow-up?** _____ **Parent Refusal for Lead Test Sign and Date Below:** _____

Date of Exam: _____ **Examiner's Name:** _____

Height: _____ **Weight:** _____ **BMI%**_____ **Any Concerns** _____**NO**

_____**YES, Specify follow-up:**_____

Vision: R_____ **L**_____ **Hearing: R**_____ **L**_____ **Blood Pressure:** _____

Immunizations Needed: _____

When recording results for the following, please enter: **N-normal, A-abnormal, NE-not evaluated.**

General Appearance: _____ Head: _____ Skin: _____ Abdomen: _____ Glands: _____

Nose/Mouth/Pharynx: _____ Heart: _____ Lungs: _____ Muscular Coordination: _____

Bones/Joints/Muscles: _____ Eyes: _____ Ears: _____ Genitalia: _____

1. Is this child allergic to foods, pets or insects? ___ **NO** **If, YES,** Specify:_____

Does this allergy require any medications or that we follow special protocols? _____**NO** _____**YES** **If Yes, our program requires a completed Treatment Plan for any identified condition(s). Please include a completed plan with the Health Summary or Fax it to (541) 444- 2307 Attention Head Start**

2. Does this child have asthma or any other condition(s) that will require medications during classtime? _____**NO** _____**YES** **If Yes, our program requires a completed Treatment Plan for any identified condition(s). Please include a completed plan with the Health Summary of Fax it to (541) 444- 2307 Attention Head Start**

3. Is any further medical treatment or specific health recommendation necessary for this child? _____**NO**

Yes, Specify: _____

Physician Signature: _____ Telephone: _____

Clinic/Office Address: _____

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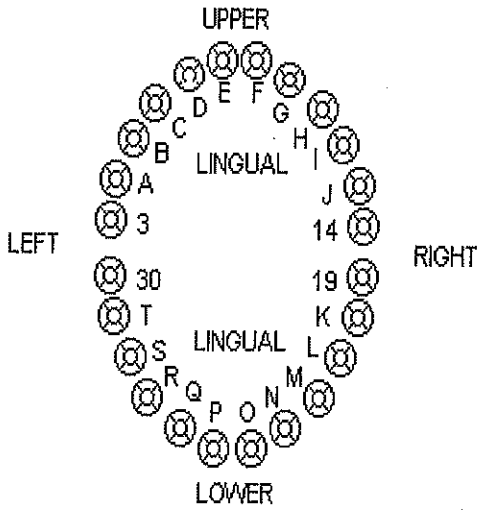
Dental Exam Form

Child's Name: _____ **D.O.B.:** _____
Parents: _____ **Date of Visit:** _____



Key: Missing Decayed Filled

EXAM:
_____Professional dental exam completed
_____X-rays Taken
_____Preventative Care Provided cleaning, fluoride, Oral health instruction

FINDINGS:
_____ All findings are within normal limits.

RESTORATIVE CARE PROVIDED:
_____ Fillings
_____ Crowns
_____ Extractions
_____ Other _____

FOLLOW UP:
_____ Further Treatment needed_____
_____

_____ Referral to: _____
_____Additional Information_____

_____
_____

******Please complete the information below******

_____ Treatment is currently **complete.**
_____ Treatment is **not complete.**
_____ Follow up appointment scheduled _____
_____ Next exam **/cleaning due:** _____ **months**

The above service(s) were completed as indicated:
Signature of Dentist: _____ Date: _____
Address and Phone:_____
Printed name and phone/stamp: _____

Please return this form Siletz Tribal Head Start
PO Box 549 Siletz, OR 97380
FAX # 541-444-2307