State of Illinois
Department of Human Services - IMSHS

APPLICANT INFORMATION

1.A. Family Circumstances and Resources (One per family)

Today's Date: _____

Parents' Name: _____

(Check One) ☐ Two-parent family ☐ Single-parent family

Is family homeless? ☐ Yes ☐ No

Does the family have a child with disabilities? ☐ Yes ☐ No

Is Child a Foster Child ☐ Yes ☐ No

☐ Migrant ☐ Seasonal

Parent/guardians currently employed in agriculture ☐ One ☐ Both

One parent/guardian currently employed in non-agriculture? ☐ Yes ☐ No

Parents in job training or school ☐ None ☐ One ☐ Both

Number of children in the family: ☐

Total combined agricultural income: $_____ Total combined other income: $_____

Yearly gross income: $_____

Section to be completed by Delegate Director Over Income? ☐ Yes ☐ No

Enrollment priority number: _____

Director's Signature: _____

1.B. Family Income

Parents' Name: _____

Complete income chart for both parents/guardians contributing to the family's total income. Write date and type of income, earned and unearned, during the past 12 months.

1st Parent/Guardian

Dates of Employment		Employer & Address or Source of Unearned Income	Amount of Income	
			Agricultural	Other

2nd Parent/Guardian

Dates of Employment		Employer & Address or Source of Unearned Income	Amount of Income	
			Agricultural	Other

1.C. Eligibility Verification Form

1. Child's name: _____ 2. Child's date of birth: _____

3. Child's date of entry into program: _____

4. Verify Eligibility. Check which category of eligibility this child falls into: TO BE COMPLETED BY DIRECTOR

Income

- ☐ Below federal poverty guidelines
- ☐ Between 100-130% federal poverty guidelines

  (no more than 35% of enrolled children may fall into this category)
- ☐ Over income *(counted as part of 10% maximum for non-AI/AN programs)*
- ☐ AIAN Over income *(counted as part of the 49% maximum for AI/AN programs)*

☐ Public Assistance

☐ Homeless

☐ Foster Care

☐ SSI

5. What documentation was used to determine eligibility?

☐ Income Tax Form 1040
☐ W-2
☐ TANF documentation
☐ Pay stub or pay envelope
☐ Unemployment
☐ Written statements from employers
☐ Foster Care Reimbursement
☐ SSI documentation
☐ Other If Other, please explain: _____
☐ Documentation of no income: _____

6. Staff Signature: _____ Date: _____

7. Director's Signature: _____ Title: _____

Date: _____

2.A. Health Records

Complete one for every child in the family that is eligible to receive Head Start services.

Parent's Name: _____ Child's Name: _____

Was your child previously enrolled in Head Start or other children's program? If yes, when? From: _____ to: _____

Address: _____
Street Town/City State Zip Telephone

Date of child's last physical exam: _____ Doctor's Name: _____

Address: _____
Street Town/City State Zip Telephone

Date of child's last visit to the dentist: _____ Dentist's Name: _____

Address: _____
Street Town/City State Zip Telephone

(Get copies or signed release of information for health or dental records.)

Does your child have immunization, health, and dental records? ☐ Yes ☐ No (If yes, obtain these from the parents)

Does your child have an Illinois medical card? ☐ Yes ☐ No (If yes, obtain these from the parents)

If no, do you need assistance with applying for one? ☐ Yes ☐ No

Is your child enrolled in WIC? ☐ Yes ☐ No If yes, county of WIC program: _____

While in this area, what is your source of health and emergency care: ☐ Migrant Clinic

☐ Other _____

2.B. Child Intake

Complete one for every NEW child entering the program.

Parent's Name: _____

Child's Name: _____ DOB: ____ / ____ / ____ ☐ M ☐ F

Child's ethnicity: (mark one) ☐ Hispanic or Latino origin ☐ Non-Hispanic / Non Latino origin

Child's race (mark one)
☐ American Indian or Alaska Native ☐ Asian
☐ African American ☐ Biracial or Multi-racial
☐ White ☐ Unspecified
☐ Native Hawaiian/Pacific Islander ☐ Other _____

Child's primary language ☐ Spanish ☐ English ☐ Other _____

These questions will help us understand your child better.

1. Can you tell me one or two things your child is interested in or does especially well?

   a. _____ b. _____

2. Does your child take a nap? ☐ Yes ☐ No

   If yes, when and how long? _____

3. Does your child have any sleeping difficulties: frequent nightmares, fretful, not sleeping at least 8 hours, etc.?

   ☐ Yes ☐ No

   If yes, explain: _____

   _____

4. How does your child act with adults that he or she does not know?

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5. How does your child act when playing with a group of other children?

6. Does your child worry a lot, or is he or she very afraid of anything? ☐ Yes ☐ No

If yes, explain _____

7. What makes your child cry? What do you do to comfort him or her?

8. Have there been any big changes or problems in your child's life in the last six months that might affect him or her?

☐ Yes ☐ No

If yes, explain: _____

9. Is there anything else you would like us to know about your child that would help us to take care of him or her?

☐ Yes ☐ No If yes, explain _____

10. Does your child have a disability? ☐ Yes ☐ No

If yes, what? _____ ☐ IEP ☐ IFSP

Does he or she need special accommodations? _____

11. Do you have any concerns with your child's development? ☐ Yes ☐ No

If yes, what? _____

12. Is your child toilet trained? ☐ Yes ☐ No Is he or she in the process of being trained? ☐ Yes ☐ No

INFANT: Does infant take: ☐ Solid Food ☐ Breast Milk # of ounces? _____ How often? _____

Type of milk (whole, formula with or without iron)? _____

NOTE: GIVE COPY TO ALL COORDINATORS AND CHILD'S TEACHER AS SOON AS CHILD IS ACCEPTED.

2.B.C.I. Child Intake & Health History - Update

Complete one for every child in the family that has PREVIOUSLY attended IMSHS and is currently eligible to receive Head Start services.

Parent's Name: _____

Child's Name: _____ Date of Birth: _____ ☐ M ☐ F

Child's primary language ☐ Spanish ☐ English ☐ Other _____

These questions will help us understand your child better.

1. Has your child developed a new interest(s) since last year? ☐ Yes ☐ No
   If Yes, explain _____
2. Does your child still take a nap? ☐ Yes ☐ No
   If yes, when and how long _____
3. Does your child have any sleeping difficulties: e.g. frequent nightmares, fretful, not sleeping at least 8 hours, etc?
   ☐ Yes ☐ No If yes, explain _____
4. Have you noticed any changes in how your child acts with adults and with other children? ☐ Yes ☐ No
   If yes, explain _____
5. Has your child developed any new fears or does your child often get cranky or cry, when you cannot figure out why?
   ☐ Yes ☐ No If yes, explain _____
6. Have there been any big changes in the last six months that might affect your child? ☐ Yes ☐ No
   If yes, describe _____
7. Is there anything else you would like us to know about your child that would help us to take the best care of him?
   ☐ Yes ☐ No If yes, explain _____
8. Does your child have a disability? ☐ Yes ☐ No If yes, what? _____ ☐ IEP ☐ IFSP
   Does he or she need special accommodations? _____
9. Do you have any concerns with your child's development? ☐ Yes ☐ No If yes, what? _____
10. Is your child toilet trained? ☐ Yes ☐ No Is she/he in the process of being trained? ☐ Yes ☐ No
    Do you want us to assist in the process? ☐ Yes ☐ No
11. Does your child have conditions that could be important in an EMERGENCY?
    Asthma: ☐ Yes ☐ No Diabetes? ☐ Yes ☐ No Seizures? ☐ Yes ☐ No
    Other: ☐ Yes ☐ No If yes, explain: _____

ALLERGIES: (DETERMINED BY A DOCTOR)

Insect bites: ☐ Yes ☐ No If yes, what insects and explain reaction: _____

Food: ☐ Yes ☐ No If yes, what foods and explain reaction: _____

Medications: ☐ Yes ☐ No If yes, what kind medicine and explain reaction: _____

INFANT: Does infant take: ☐ Solid Food ☐ Breast Milk # of ounces? _____ How often? _____

Type of milk (whole, formula with or without iron)? _____

2.C. Health History

Complete one for every NEW child entering the program.

Child's Name: _____ Parent's Name: _____

1. Did mother have any health problems during pregnancy or delivery? ☐ Yes ☐ No
   If yes, explain _____
2. Did mother visit physician fewer than two times during pregnancy? ☐ Yes ☐ No
   If yes, explain _____
3. Was child born outside of a hospital? ☐ Yes ☐ No
   If yes, explain _____
4. What was child's weight at birth? _____ Lbs. _____ Oz.
5. Did child or mother stay in hospital longer than usual? ☐ Yes ☐ No
   If yes, why? _____
6. Is mother pregnant now? ☐ Yes ☐ No
7. Is child now being treated by a physician or a dentist? ☐ Yes ☐ No
   If yes, explain _____
8. Does child often have: (mark all that apply)
   ☐ sore throat ☐ cough ☐ earaches ☐ eye infections ☐ colds
   ☐ vomiting ☐ diarrhea ☐ urinary infections ☐ stomach pain

Explain answers

9. Has child had: ☐ chicken pox ☐ mumps ☐ measles ☐ German measles ☐ polio
   ☐ scarlet fever ☐ whooping cough ☐ rheumatic fever ☐ liver disease

Explain answers

10. Does child have any health problems that affect his or her every-day activities? ☐ Yes ☐ No
    If yes, describe _____
    Did a doctor or other health professional tell you the child has this problem? ☐ Yes ☐ No
    If yes, when? _____