# Red Lake Nation Head Start

P.O. Box 53 Red Lake, MN. 56671

Phone: 218-679-3396 – Fax: 218-679-2923

Ponemah Site

P.O. Box 262 Ponemah MN. 56666

Phone: 218-554-7331 – Fax 218-554-7386

## Enrollment Packet

Child's Name: _____ Date of Birth: _____

**OFFICE USE ONLY**

| Documentation Required | Date Received | Application Status |
|---|---|---|
| ___ Birth Certificate | _____ | |
| ___ Immunizations | _____ | Incomplete: ___ |
| ___ Physical | _____ | |
| ___ Income/All sources | _____ | Complete: ___ |
| ___ Guardianship/Court Paper | _____ | |
| ___ Preschool Screening or Date of Appointment | _____ | |

Your application will be given first consideration for enrollment if you submit all the documents required.

Please answer all questions. Sign and date where necessary and if you have any questions regarding the application, please feel free to call and a staff member will be happy to assist you.

**ENROLLMENT FOR OFFFICE USE ONLY**

| DATE RECEIVED (PLEASE STAMP) | RECEIVED BY: | ADD DATE:<br><br>DROP DATE:<br><br>RE-ENROLL DATE: | CLASSROOM:<br>____ WOLF<br>____ TURTLE<br>____ EAGLE<br>____ MARTEN<br>____ BEAR<br>____ KINGFISHER<br>____ BULLHEAD<br>____ WAABOOZ<br>____ MAANG<br>____ MIGIZII |
|---|---|---|---|

# Red Lake Nation Head Start Enrollment Application

Please check one: ___New Student ___Returning Student ___Update Application

Center Location: _____ School Year: _____

**CHILD APPLICANT:**

**Name:** _____ **Date of Birth:** _____ Gender: M / F

**Is this a Foster Child?** ___ Yes ___ No Ethnicity ___ Hispanic ___ Non-Hispanic

**Race:** ___ American Indian/Alaska Native – Tribal Affiliation/Enrollment _____

___ Asian ___ Black ___ Hawaiian/Pacific Islander ___ White ___ Other _____

**English Proficiency:** ___ Proficient ___ Poor ___ Moderate ___ None Other Language: _____

Doctors Name & Phone Number Dentists Name & Phone Number

_____ _____

Insurance Information: ___ Health Insurance ___ I.H.S. ___ Medicaid ___ Other: _____

Does your child have a disability or do you have any concerns about your child's development? Yes / No

If yes explain: _____

**CONTACT INFORMATION:**

Physical Address: _____ Mailing Address: _____

_____ _____

Primary Phone Number: _____ Alternate Phone Number: _____

Cell phone number: _____ Email Address: _____

**PRIMARY PARENT/GUARDIAN**

**Name:** _____ **Date of Birth:** _____ Custody: Yes / No

**Relationship to Child:** _____ ___ Lives w/family __ Provides Financial Support

**Employment Status:** ___ Full Time 35 Hrs. or more ___ Part Time Less than 35 Hrs. ___ Seasonal

___ Unemployed ___ Full Time & Training ___ Part Time & Training ___ In Training or School ___ Retired

___ Disabled

___ Highest Grade Completed ___ High School Diploma/GED ___ Some College ___ College Graduate

**Race:** ___ American Indian/Alaska Native – Tribal Affiliation/Enrollment _____

___ Asian ___ Black ___ Hawaiian/Pacific Islander ___ White ___ Other _____

**English Proficiency:** ___ Proficient ___ Poor ___ Moderate ___ None Other Language: _____

**Place of Employment:** _____

**Phone Number:** _____

**SECONARY OR OTHER PARENT/GUARDIAN**

**Name:** _____ **Date of Birth:** _____ Custody: Yes / No

**Relationship to Child:** _____ ___ Lives w/family __ Provides Financial Support

**Employment Status:** ___ Full Time 35 Hrs. or more ___ Part Time Less than 35 Hrs. ___ Seasonal

___ Unemployed ___ Full Time & Training ___ Part Time & Training ___ In Training or School ___ Retired

___ Disabled

___ Highest Grade Completed ___ High School Diploma/GED ___ Some College ___ College Graduate

**Race:** ___ American Indian/Alaska Native – Tribal Affiliation/Enrollment _____

___ Asian ___ Black ___ Hawaiian/Pacific Islander ___ White ___ Other _____

**English Proficiency:** ___ Proficient ___ Poor ___ Moderate ___ None Other Language: _____

**Place of Employment:** _____

**Phone Number:** _____

***FAMILY INFORAMTION*** (please mark all that apply)**

| **Homeless** **Do you?** | **Parental Status** | **Active Military** | **Veteran** |
|---|---|---|---|
| ___ Yes* ___ Own home | ___ One Parent ___ Foster | ___ Yes | ___ Yes |
| ___ No ___ Rent | ___ Two Parent | | |
| ___ Live with Relatives* | ___ Other: _____ | ___ No | ___ No |
| **If yes, please fill out Documentation Of Homelessness* | | | |

**ADDITIONAL FAMILY**

*Family means all persons living in the same household who are supported by the child's parent(s) or guardian(s) income and are related to the child's parent(s) or guardian(s) by blood, marriage or adoption; or are the child's authorized legal caregiver.*

| NAME OF FAMILY MEMBER | DATE OF BIRTH **Required** | RELATIONSHIP TO CHILD | GENDER *MALE OR FEMALE* | RACE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**EMERGENCY CONTACTS** *(Must not be parent or guardian and must have 2 contacts)*

Name: _____ Name: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Relationship to Child: _____ Relationship to Child: _____

Please provide **SPECIFIC** directions to your home: _____

_____.

**ALTERNATE DROP OFF LOCATION** ***(MUST HAVE APPROVAL)***

If you are not home for your child at drop off time, please provide an alternate drop off location for your child. (Must have approval from alternate drop off location): _____

_____

Name: _____ Phone Numbers: _____

**ANY OTHER CHILDREN ENROLLED IN HEAD START. WHO?** _____

Interview conducted ___ In person ___ Phone (Documented on Phone Log)

I certify that the information on this application is true and correct and I understand that it will be used in determining eligibility for enrollment and by signing below; you agree to allow the Red Lake Nation Head Start Program to verify all the information provided.

_____ _____

Signature of Parent/Guardian Date

# Certification of Income Verification

## Attach documentation of ALL household income.

Has your income changed drastically in the past few months? ___ Yes ___No If yes, please explain:

_____

**SERVICES OR FINANCIAL ASSISTANCE YOU RECEIVE:** *(check all that apply)*

| | | | |
|---|---|---|---|
| ___ Child Care Subsidies | ___ Child Support/Alimony | ___ Energy Assistance | ___EPSDT |
| ___ Medical Assistance | ___ Foster care/Adoption | ___ General Assistance | ___ SNAP |
| ___ Public Assistance/TANF | ___ Public Housing | ___ Retirement/Pension | ___ SSI |
| ___ WIC | ___ VA | ___ Relative Care | ___ Unemployment |

**CHECK ALL SOURCES TO DETERMINE HOUSEHOLD INCOME:** *(Must provide proof with application)*

| | | | |
|---|---|---|---|
| ___ Pay Stub(s) | ___ Public Assistance/TANF | ___ VA | ___ General Assistance |
| ___ Tax Forms/W-2 | ___ Retirement/Pension | ___ Self-Employment | ___ Unemployment |
| ___ Child Support/Alimony | ___ Foster Care Document | ___ SSI | ___ Employer Verification |
| ___ No Income * | | | |

**If you checked No Income, you need to fill out the Declaration on No Income Form provided with application.**

I have provided all the Income sources from all the checked above:

Signature: _____ Date: _____

Verified by: _____ Date: _____

Red Lake Nation Head Start

Child Medical, Dental and Health Questionnaire

**This document is CONFIDENTIAL and is kept in a locked file cabinet. **

Child's name: _____ Date of Birth: _____

**HEALTH:**

Does your child: ____ Wear glasses ____ Use hearing aids ____ Use a wheel chair ____ Other

Does your child have any allergies or food allergies? ____Yes ____ No If yes? Please explain

_____.

**You will need to provide a doctors slip with your application describing all allergy symptoms and all foods your child is allergic to.**

Does child or any family member have a history of Hereditary Angioedema? ____ Yes ____ No

Does your child have any of the following? Please mark all that apply to your child.

__ Eye problems __Ear problems __ Nose trouble __ Hearing Trouble __ Throat trouble

__ Foot trouble __ Heart trouble __ Sleeping trouble __ Thyroid trouble __ Kidney trouble

__ Bladder trouble __ Stomach trouble __ Liver trouble __ Intestinal problems __ Asthma

__ Gall Bladder trouble __ Broken bones __ Deformity of bones/joints __ Swollen/Painful joints

__ Arthritis __ Severe headaches __ Rheumatic/hay fever __ Sinusitis __ Chronic colds/cough

__ Bronchitis __ Emphysema __ Shortness of breath __ Dizzy/fainting spells __ Amnesia

__ Chest pain __ Head injury __ Depression __ High/low blood pressure __ Weight loss/gain

__ Carsickness __ Eczema __ Blood disorders __ Painful urination __ Stroke __ Jaundice

__ Glaucoma __ Tuberculosis __ Cleft palate/lip __ abnormal chest x-ray/EKG __ Hepatitis

__ Growths/cysts __ Cancer/tumors __ Blood transfusions __ Epilepsy/seizures __ Paralysis

__ Steroid therapy __ Diabetes Other: _____

Does your child have an IEP (Individual Education Plan) or an IFSP (Individual Family Service Plan). __ Yes __ No If yes? Where? _____

**DENTAL HEALTH:**

When was your child's last dental visit? _____ Completed dental screening. __ Yes __ No

Dental concerns? __ Bleeding gums __ Toothache __ Crooked __ Missing __ Loose teeth

__ Food trapping __ Bad breath other: _____

**MENTAL HEALTH:**

Are there any Mental Health concerns in the home? __Yes __ No If yes explain: _____

Is there any of the following in the home? __ Child abuse __ Neglect __ Substance abuse

Any of these documented. __Yes __No if yes? Where: _____

**I certify that all the above information is true and correct and have not omitted any information.**

_____ _____

Signature Parent/Guardian Date

# Red Lake Nation Head Start Policies

## Attendance Policy

ATTENDANCE IS VERY IMPORTANT FOR YOUR CHILD.

Your child MUST be signed in/out when he/she is dropped off or picked up. Signatures, dates and times need to be recorded for each day.

If your child is absent, PLEASE NOTIFY the school AS SOON AS POSSIBLE by calling ahead of time. We are responsible for documenting absences in the attendance records and need an explanation of why your child has not been in school. If your child is absent three consecutive days, we will call to make an appointment for a home visit. Chronic Absenteeism may result in your child to be dropped from our program.

Child Protective Services will be called if your child is not picked up by 4:30 P.M. and you have not contacted us about an emergency or an unavoidable situation.

Excused Absences: Illness or serious injury, death in the family, medical, dental or therapy appointments that could not be scheduled outside of class and Foster Care transitions.

## Parent/Guardian Responsibility

Children will NOT be accepted into the classroom before 7:45 A.M. Children are NOT allowed to be dropped off outside the school and are REQUIRED to be signed in at the front office

Please call the school before 8:15 A.M. if your child will be absent and before 3:30 P.M. if your child gets off the bus at a different location.

Parents/Guardians MUST show some visible sign for the bus staff to know that someone IS HOME.

Please teach your child to "Wait until the bus has come to a complete stop before getting on and off the bus"

## Parent Volunteer Survey

All Parents/Guardians are considered members of the "Head Start Parent Committee" if your child is enrolled in the program.

Our Head Start depends on shared decision making with parents/guardians, therefore, we need volunteers to serve on the

"Parent Policy Council". One parent/guardian is voted to the policy Council from each classroom and will meet as often as possible. Policy Council members are reimbursed. I am willing to volunteer to serve on the "Parent Policy Council" Please check one:

YES_____ NO_____

# Health Policy

Enrolled students MUST HAVE age appropriate preventative and primary health care, which includes:

Medical, Dental and Mental Health Care.

Federal Rules and Regulations require your child to have the following information in his/her file.

1. Birth Certificate
2. Child's Head Start Physical, which includes:
   Blood work:
   Hemoglobin
   Hematocrit
   Lead
   BMI
   Height/Weight
   Blood Pressure
   Vision/Hearing
3. Child's Immunization Record which includes:
   Diphtheria
   Tetanus
   Pertussis (Whooping Cough)
   Polio (Oral & IPV)
   Mumps, Rubella, Rubeola
   Hepatitis A & B
   HIB/Peduax
   Varicella
   TB
4. Child's Dental Examination

By signing this document, I have read and understand the policies of the Red Lake Nation Head Start.

Parent/Guardian Signature Date

# Child and Adult Care Food Program – CACFP
# Child Enrollment Form
# Red Lake Nation Head Start

**Child's name:** _____ **D.O.B:** _____ **Male/Female**

**(Print) Parent/Guardian name:** _____

**Mailing Address:** _____ **City:** _____

**State:** _____ **Zip:** _____ **Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____

This facility participates in the U.S. Department of Agriculture (USDA) & Child and Adult Care Food Program (CACFP) and receives federal cash assistance to serve healthy meals to your child at no cost to you. In order to participate and receive reimbursement for meals, this facility has agreed to follow the USDA guidelines. The USDA's CACFP needs verification of enrollment annually for each participant in this facility. Meals served here must meet nutrition requirements established by the USDA's CACFP. Good nutrition today means a stronger tomorrow.

**Check the days your child normally/will attend/s:** ___ **Mon.** ___ **Tue.** ___ **Wed.** ___ **Thur.** ___ **Fri.**

**Write the hours your child normally/will attend/s: Start time:** _____ **End time:** _____

**Check the meals your child normally/will receive/s:** ___ **Breakfast** ___ **AM Snack** ___ **Lunch** ___ **PM Snack** ___ **Supper**

**State Contact Information**

Minnesota Department of Education – Food and Nutrition service

1500 Highway 36 West, Roseville, MN. 55113

1-651-582-8526 or 1-800- 366-8922 mde.fns@state.mn.us

## Civil Rights Information

Provisions of this information is voluntary and has no effect on benefits received by you or the facility. This information is used to determine whether the facility is complying with Civil Rights Laws. If you do not provide this information, a representative is required to identify the ethnic and racial categories of your child in care at this facility.

**Check all that apply to your child:**

**Child Ethnicity:** ___ **Hispanic or Latino** ___ **Non-Hispanic or Latino**

**Child Race:** ___ **Native American or Alaskan** ___ **Native Hawaiian or other Pacific Islander** ___ **Black or African American**

___ **Asian** ___ **White** ___ **Other:** _____

**Identified by:** ___ **Adult Household Member** ___ **Child Care Representative**

In accordance with Federal and U.S Department of Agriculture policy, this institution is prohibited from discriminating based on race, color, national origin, sex, age, or disability. To file a complaint, contact USDA Director, Office of Civil Rights, 1400 Independence Avenue SW. Washington, DC. 20250 - 9410 or call toll free 1-866-653-9992 (voice). Individuals who are hearing impaired or have speech difficulties may contact through Federal Relay Service at 1-800-845-8339 or 1-800-845-6136 (Spanish). USDA is an equal opportunity provider and employer.

**Parent/Guardian Signature:** _____ **Date:** _____

**This institution is an equal opportunity provider and employer**

# Your Privacy Rights

The purpose of the information we collect from you is defined below. Details about the purposes of the information we collect is often listed on forms you are asked to complete. The data we collect may be used for the following purposes:

- Determine your eligibility for services provided by this agency.
- Provide effective care and treatment of medical, social, psychological problems.
- Enable us to collect federal, state, and local funds for services.
- Determine your ability to pay for medical treatment or other aids and services provided to you or to other persons for whom you are responsible.
- Prepare statistical reports and evaluations.
- Conduct program and financial audits.
- Collect reimbursements from other agencies or individuals for services or assistance we give you.

## LEGAL REQUIREMENTS

In most cases, you are not legally required to provide the information requested. If you are legally required to supply the information requested, you will be informed which law requires it.

If you do not provide the information requested, we may not be able to determine your eligibility for the services we provide. In some cases, providing services will be delated or hindered if you refuse to provide the information.

## SHARING INFORMATION

The information that you provide will only need to be shared with other employees or agents of the statewide welfare system ONLY when programs require access.

The information you provide will be shared **only** for the following circumstances:

- To individuals, persons, agencies, institutions or organizations **you** authorize sharing by a valid consent for Release of Information.
- To court systems from a court order.
- To administer federal funds or programs.
- To appropriate law enforcement personnel who are acting in an investigation, prosecution, criminal or civil proceeding relating to an administration of a program.
- To appropriate parties in an emergency.

We may share this information with the following:

State and Local welfare agencies – Community Based Organizations – Local and State public and private Health and Human Service Agencies – The Minnesota Department of Economic Security – The United States Department of Labor – The United States Departments of Health and Human services – Local and State Education Programs, as allowed by law.

Details about how the information will be shared may be provided on the forms you will be asked to complete. If you need additional, information a staff person will assist you to receive it. You have the right to know and have access to any information maintained about you. You also have the right to have it explained to you.

I have read this explanation of my Privacy Rights. I understand the reasons for releasing the information, and who is authorized to use it.

**Signature of Parent/Guardian:** _____ **Date:** _____

# Red Lake Nation Head Start

P.O. Box 53 Red Lake, MN. 56671
Phone: 218-679-3396 Fax: 218-679-2923

## Permission to Obtain, Exchange and Release Information about this child:

Child's Name_____ Date of Birth_____

**Medical/Dental:**

From: (check all that apply)

___ Red Lake IHS Hospital/Medical Records Red Lake MN. ___ Sanford Health/Medical Records Bemidji MN.

___ Cass Lake IHS Hospital/Medical Records Cass Lake MN. ___ Mental Health Consultation

___ Dental: _____ Other Facility: _____

For: Physical/Health Record, Immunization Record, Hematocrit, Hemoglobin and Lead Tests, Dental Records, Mental Health Record any Referral Follow-up.

**Human Services:**

From: (check all that apply)

___ Oshkiimaajaatada New Beginnings Redby MN. ___ Family & Children Services Red Lake MN.

___ Beltrami County Bemidji MN. ___ Cass County Cass Lake MN.

___ Hennepin County Minneapolis MN. ___ Other Facility_____

For: Verification of Public Assistance, Verification of Health Care, Guardianship Documents, Birth Certificates, Referral Follow-up, other Documents as needed.

**School Records:**

From: (check all that apply)

___ Red Lake ISD Red Lake MN. ___ Bemidji ISD Bemidji MN. ___ Kelliher ISD Kelliher MN.

___ Clearbrook/Gonvick ISD Clearbrook MN: ___ Blackduck ISD Blackduck MN.

___ Other School:_____

For: Official Student Record, Individualized Education Plan (IEP), Pre-School Screening -Hearing, vision, speech, heights, weights, DIAL- Motor Concepts, ASQSE-Social & Emotional Behavior, Child Health & Development – Health, Nutrition, Dental, Daily Routines, Home Safety & Learning, Psychological Evaluations, and other school documents as needed.

**Other Consents:**

Emergency Medical/Dental/X-ray Treatment - Transportation/Bus Service – School Field Trips/Activities. Use of Photograph/Video for Head Start Brochures, School Bulletin Boards etc.

I, (print name)_____, authorize the Red Lake Nation Head Start to obtain, exchange or release information with above named agencies, only as needed for the direct benefit of my child, whose name and date of birth is written above. I understand this information will Not be re-released without my consent. This permission is valid three years from the date of my signature.

_____ _____

Parent/Guardian Signature Date

**Red Lake Nation Head Start**
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**Phone: 218-554-7331 – Fax: 218-554-7286**

# Employment/Income Verification Letter

Employer Name: _____

Address: _____

City: _____ State: _____

Zip: _____

RE: Verification of Employment for _____ (Name of Employee)

To Red Lake Nation Head Start,

Please accept this letter as confirmation that _____ (Name of Employee) has been employed with _____ (Employer Name) Since _____. (Employee Start Date).

Currently, _____ (Name of Employee) holds the Title of _____ and works on a ____Full-Time ____Part-Time of _____ hours per week while earning $ _____ payable on a ____ Hourly ____ Daily ____ Weekly ____ Bi-weekly ____ Monthly basis.

Thank you,

Signature: _____ Print Name: _____

Employer Title: _____

Date: _____

# Document of Homelessness

*** Legal Definition of Homelessness***

## §11434a. Definitions

For purposes of this part:

(1) The terms "enroll" and "enrollment" include attending classes and participating fully in school activities.

(2) The term "homeless children and youths"—

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 11302(a)(1) of this title); and

(B) includes—

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 11302(a)(2)(C) [1] of this title);

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 6399 of title 20) who qualify as homeless for the purposes of this part because the children are living in circumstances described in clauses (i) through (iii).

(3) The terms "local educational agency" and "State educational agency" have the meanings given such terms in section 7801 of title 20.

(4) The term "Secretary" means the Secretary of Education.

(5) The term "State" means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

(6) The term "unaccompanied youth" includes a homeless child or youth not in the physical custody of a parent or guardian.

(Pub. L. 100–77, title VII, §725, as added Pub. L. 107–110, title X, §1032, Jan. 8, 2002, 115 Stat. 2005; amended Pub. L. 114–95, title IX, §§9105(a), 9215(zz), Dec. 10, 2015, 129 Stat. 2136, 2184.)

### REFERENCES IN TEXT

Section 11302 of this title, referred to in par. (2)(B)(ii), was amended by Pub. L. 111–22, div. B, §1003(a)(2), May 20, 2009, 123 Stat. 1664, and, as so amended, section 11302(a)(2) of this title no longer contains a subpar. (C).

### PRIOR PROVISIONS

A prior section 11434a, Pub. L. 100–77, title VII, §725, as added Pub. L. 103–382, title III, §323, Oct. 20, 1994, 108 Stat. 3965, defined terms, prior to the general amendment of this part by Pub. L. 107–110.

Another prior section 11434a, Pub. L. 100–77, title VII, §725, as added Pub. L. 101–645, title VI, §613(2), Nov. 29, 1990, 104 Stat. 4743, related to reports by Comptroller General, prior to the general amendment of this part by Pub. L. 103–382.

A prior section 725 of Pub. L. 100–77 was renumbered section 726 and was classified to section 11435 of this title, prior to the general amendment of this part by Pub. L. 103–382.

# Document of Homelessness

### AMENDMENTS

**2015**—Par. (2)(B)(i). Pub. L. 114–95, §9105(a)(1), inserted "or" before "are abandoned" and struck out "or are awaiting foster care placement;" after "hospitals;".

Par. (3). Pub. L. 114–95, §9215(zz), made technical amendment to reference in original act which appears in text as reference to section 7801 of title 20.

Pub. L. 114–95, §9105(a)(2), which directed technical amendment to reference in original act which appears in text as reference to section 7801 of title 20, could not be executed because of the intervening amendment by Pub. L. 114–95, §9215(zz). See above and Effective Date of 2015 Amendment notes below.

Par. (6). Pub. L. 114–95, §9105(a)(3), substituted "homeless child or youth not" for "youth not".

### EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by section 9215(zz) of Pub. L. 114–95 effective Dec. 10, 2015, except with respect to certain noncompetitive programs and competitive programs, see section 5 of Pub. L. 114–95, set out as a note under section 6301 of this title.

Pub. L. 114–95, title IX, §9105(b), Dec. 10, 2015, 129 Stat. 2137, provided that:

"(1) In general.—In the case of a State that is not a covered State, the amendment made by subsection (a)(1) [amending this section] shall take effect on the date that is 1 year after the date of enactment of this Act [Dec. 10, 2015].

"(2) Covered state.—In the case of a covered State, the amendment made by subsection (a)(1) shall take effect on the date that is 2 years after the date of enactment of this Act."

Amendment by section 9105(a) of Pub. L. 114–95 effective Oct. 1, 2016, except as provided in section 9105(b) of Pub. L. 114–95 (set out above), see section 9107 of Pub. L. 114–95, set out as a note under section 11431 of this title.

### EFFECTIVE DATE

Section effective Jan. 8, 2002, except with respect to certain noncompetitive programs and competitive programs, see section 5 of Pub. L. 107–110, set out as a note under section 6301 of Title 20, Education.

### DEFINITION OF COVERED STATE

Pub. L. 114–95, title IX, §9105(c), Dec. 10, 2015, 129 Stat. 2137, provided that: "For purposes of this section [amending this section and enacting provisions set out as a note above] the term 'covered State' means a State that has a statutory law that defines or describes the phrase 'awaiting foster care placement', for purposes of a program under subtitle B of title VII of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.)."

# Red Lake Nation Head Start

## Documentation of Homelessness

*** Legal Definition of Homelessness ***

According to the section 725(2) of the McKinney-Vento Homeless Assistance Act (42 E.S.C. 11434a(2)), the term "homeless children and youths" –

(A) means individuals who lack a fixed, regular, and adequate nighttime residence...; and

(B) includes

(i) children and youths who are sharing housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings...;

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

**Child's Name:** _____ **Birthdate:** _____

This document is to **certify** the above individual and/or family is currently homeless based on the category checked below:

____ Individual and/or family who lacks a fixed, regular, and adequate nighttime residence:
____ Individual and/or family who is residing with other family or friends:
____ Individual and/or family who is residing at a Homeless Shelter or Women's Shelter:

This document is to **verify** the above individual and/or family is currently homeless based on the category checked below:

____ Parent/Guardian attests that they are currently living at _____ Residence.
(Indicate the family, Friend, or (i), (ii), (iii) above)
____ Parent/Guardian attests that they are moving from place to place in search of adequate housing.
____ Parent/Guardian attests they reside at the Homeless shelter / Women's Shelter.
____ Parent/Guardian attests they are on the Housing List for a Home/Rental.

By signing this document below, I certify, to the best of my knowledge, the above information is true and correct, to confirm my eligibility to enroll in the Red Lake Nation Head Start Program and do hereby give consent to the Head Start Staff to confirm homelessness with those listed on this form.

_____

**Parent/Guardian Signature** **Date**

***Contacted _____ at _____ on _____ at _____ a.m./p.m.
(Name) (Phone #) (Date) (Time)

**FCP Coordinator/Staff Signature:** _____

# Red Lake Nation Head Start

## Declaration of **NO INCOME**

**Child Name:** _____ **Birthdate:** _____

I, (Print Name) _____, certify that I currently **DO NOT** have any income.

I have had **No Income** since (Date) _____.

Please provide a brief summary describing your situation of NOT having an income.
(Example: Lost job because...: Unreliable child care circumstances: Transportation issues...: Lost home...: etc.)

_____

_____

_____

_____

I DO NOT expect to receive any income until _____

_____.

By initialing to the left of each statement and signing below, I agree that:

_____ I understand that **verification of income** is required to determine eligibility for enrolling my child into the Red Lake Nation Head Start Program.

_____ I understand that **'No Income'** or **'Zero Income'** means that I do not receive any money through employment, or from other sources including, but not limited to, employment, alimony, child support, retirement, Social Security Disability Income (SSI), TANF/MFIP, etc.

_____ I certify that I do not have any income and I will notify the Red Lake Nation Head Start Program if I receive, or start receiving any Income.

_____ I understand that the Red Lake Nation Head Start may verify information on this form by contacting Human Services listed on the "Permission to Obtain, Exchange and Release Information" page that is included in the Head Start Application.

By signing this document below, I certify, to the best of my knowledge, the above information is true and correct, to confirm my eligibility to enroll in the Red Lake Nation Head Start Program.

_____

Parent/Guardian Signature Date

RED LAKE COMPREHENSIVE HEALTH SERVICES
SCHOOL DENTAL PREVENTION PROGRAM
**(218) 679-0395**

# Informed Consent for Silver Diamine Fluoride (SDF)

Silver Diamine Fluoride (SDF) is an antimicrobial liquid. SDF can be used to treat cavities, to help stop tooth decay, as well as treating tooth sensitivity. The use of Silver Diamine Fluoride in dentistry has been well documented for its safe and successful ability to control tooth decay. Its application is a conservative approach for the treatment of active decay.

**Benefits of receiving SDF:**

1. Help stop tooth decay
2. Relieves tooth sensitivity
3. Non-invasive
4. Painless
5. Quick Treatment time

**Risks Related to SDF include, but are not limited to:**

1. The affected area will **STAIN BLACK** permanently. **HEALTHY TOOTH STRUCTURE WILL NOT STAIN**. Stained tooth structure can be replaced with a filling or a crown.
2. Tooth colored fillings and crowns may discolor if SDF is applied to them. Color changes on these surfaces can normally be polished off. The edge between a tooth and filling may remain stained
3. If accidently applied to the skin or gums, a brown or white stain may appear that causes **NO HARM,** cannot be washed off and will disappear in 1-3 weeks
4. A metallic taste may be present but will resolve itself rapidly.

These side effects may not include all of the possible situations reported by the manufacturer. If you notice other effects, please talk with your dental provider.

**Patients should not be treated with SDF if:**

1. Allergic to Silver
2. There are painful sores or raw areas on the gums or anywhere in the mouth

Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and No Guarantee of success is granted or implied. If the decay is not arrested, the decay will progress. In that case, the tooth will require further treatment, such as a repeat SDF, a filling or crown, root canal treatment or extraction. Understand that your child's **DIET** and **ORAL HYGIENE** will influence the results and protection from future decay.

If you decide not to have the SDF application for your child, it may result in continued deterioration of tooth structure. Symptoms may increase in severity and may require advanced treatment modalities such as sedation or general anesthesia.

**CIRCLE THE NUMBER FOR YOUR CHOICE AND COMPLETE THE PERSONAL INFORMATION.**

1. **I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALLOW THAT MY CHILD CAN RECEIVE THIS BENEFIT.**

2. **I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND DO NOT WISH MY CHILD TO RECEIVE THIS BENEFIT.**

**NAME**_____**DOB**_____**TEACHER**_____

**GUARDIAN**_____**CONTACT PHONE NUMBER**_____

**FOR QUESTIONS OR CONCERNS PLEASE FEEL FREE TO CONTACT BETH SCHMID, RDH AT 218-679-0395. IF WE ARE AWAY FROM OUR OFFICE PLEASE LEAVE A MESSAGE WE WILL RETURN YOUR CALL AS SOON AS WE ARE ABLE.**

* please fill out both sides *

RED LAKE NATION COMPREHENSIVE HEALTH SERVICES

# SCHOOL DENTAL SEALANT/FLUORIDE VARNISH PREVENTION PROGRAM

DEAR PARENT:

YOUR CHILD'S SCHOOL HAS CHOSEN TO PARTICIPATE IN THE RED LAKE NATION SCHOOL DENTAL PREVENTION PROJECT. AS YOU KNOW, A HEALTHY MOUTH IS PART OF TOTAL HEALTH AND WELLNESS, AND MAKES A CHILD MORE READY TO LEARN.

THE DENTAL TEAM, WHICH CONSISTS OF A LICENSED DENTAL HYGIENIST AND DENTAL ASSISTANT EMPLOYED BY RED LAKE COMPREHENSIVE HEALTH SERVICES AND SUPERVISED BY THE RED LAKE HOSPITAL DENTAL CLINIC DENTISTS, WILL SCREEN YOUR CHILD'S TEETH TO CHECK FOR TOOTH DECAY AND OTHER DENTAL PROBLEMS. YOUR CHILD WILL RECEIVE A TOOTHBRUSH AND ORAL HYGIENE INSTRUCTIONS. YOU WILL RECEIVE A REPORT ON THE HEALTH OF YOUR CHILD'S TEETH AND RECOMMENTATIONS FOR FURTHER CARE BY A DENTIST.

**THIS SCREENING DOES NOT TAKE THE PLACE OF REGULAR DENTAL EXAMS BY A LICENSED DENTIST.**

**WHEN YOU SIGN THE CONSENT FORM BELOW GIVING PERMISSION FOR YOUR CHILD TO PARTICIPATE IN THIS PROGRAM, YOUR CHILD WILL BE ABLE TO HAVE THEIR TEETH CLEANED, FLUORIDE APPLICATIONS, DENTAL SEALANTS APPLIED TO UNDECAYED TEETH AND TEMPORARY SEDATIVE MATERIAL PLACED FOR RELIEF OF PAIN. THESE PREVENTATIVE AND PALLIATIVE SERVICES HELP REDUCE THE RISK OF DENTAL DISEASE.**

YOUR CHILD WILL NOT BE NAMED IN ANY REPORTS BUT WE DO ASK FOR CONSENT TO USE PHOTOS OF YOUR CHILD PARTICIPATING IN THE DENTAL PROJECT WHICH WE OCCASIONALLY PLACE IN THE LOCAL NEWSPAPER AND AT OTHER HEALTH EVENTS. PLEASE CALL RED LAKE SCHOOL DENTAL PROJECT HYGIENIST, BETH SCHMID AT **218-679-0395 IF** YOU HAVE ANY QUESTIONS.

**THE PRIVACY RULES OF THE HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT OF 1996 WILL BE STRICTLEY ADHERED TO. TO EXERCISE YOUR RIGHTS UNDER HIPPA, TO REQUEST ADDITIONAL INFORMATION, OR TO REPORT A PROBLEM, PLEASE CONTACT THE HIPPA COORDINATOR AT RED LAKE PHS HOSPITAL 218-679-3912.**

**WE WILL ACCESS ELECTRONIC HEALTH INFORMATION ABOUT YOUR CHILD FOR THE FOLLOWING PURPOSES:**

- **TREATMENT**
- **PAYMENT**
- **CARE OPERATIONS**

_____**YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE AND TO ACCESS THEIR HEALTH RECORD AS NEEDED FOR DENTAL CARE. IF MY CHILD ENROLLS IN HEADSTART THEY MAY RECEIVE FLUORIDE SUPPLEMENTS IN SCHOOL.**

_____**NO, I DO NOT GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS PROGRAM**

**CHILD'S NAME** _____ **DATE OF BIRTH** _____

**GUARDIAN SIGNATURE** _____ **DATE** _____

**SCHOOL** _____ **TEACHER** _____ **GRADE** _____

IF YOU HAVE AGREED TO HAVE YOUR CHILD RECEIVE THE SCHOOL DENTAL PROGRAM SERVICES, PLEASE LIST BELOW ***ANY*** **HEALTH CONCERNS, SPECIAL NEEDS AND** ***ALL*** **MEDICATIONS THEY ARE TAKING.**

_____

_____

# Red Lake Nation Head Start

P.O. Box 53, Red Lake, MN 56671
Phone #: 218-679-3396 / Fax #: 218-679-2923

**Ponemah Site**

P.O. Box 262, Ponemah, MN 56666
Phone #: 218-554-7331 / Fax #: 218-554-7386


# Head Start: Dental Form/ Dentist Report

Name of Clinic:_____ Date:_____

Address (include City, State & Zip Code):_____

Childs Name: **Last** **First** **Middle** Birthdate:

_____/_____/_____ ____/____/____

Parent/Guardian Name(s):_____

Child has received the following treatment: (Check all that apply)

___ Dental Examination ___ X-Rays ___Topical Fluoride Application

___ Cleaning ___ Sealant Application ___Fillings

___ Extractions ___ Steel Crowns ___Space Maintainers

___ Other:_____

___ ALL Treatment is COMPLETE

___ ALL Treatment is NOT COMPLETE, if so;

The Following treatment is still needed: (Check all that apply)

___ Dental Examination ___ X-Rays ___ Topical Fluoride Application

___ Cleaning ___ Sealant Application ___ Fillings

___ Extractions ___ Steel Crowns ___ Space Maintainers

___ Other:_____

Additional Comments:_____

NEXT APPOINTMENT DATE: _____

Dental Provider's Signature:_____

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# Head Start: Physical Exam Form

Child's Name:_____

Date of Birth:_____ Sex: M or F (circle one)

Parents/Guardians Names:_____

_____

Name of Clinic:_____

Health Providers Signature:_____

Printed name of Health Provider:_____

Date of Exam:_____

| Area | N or AB | Comments: | Area | N or AB | Comments: |
|---|---|---|---|---|---|
| Head | | | Spine | | |
| Face | | | Cardiovascular | | |
| Neck | | | Abdomen | | |
| Eyes | | | Genitalia | | |
| Ears | | | Extremities | | |
| Nose | | | Joints | | |
| Mouth | | | Muscle Tone | | |
| Throat | | | Skin | | |
| Chest | | | Neurological | | |

**Please note: These Items are Federally mandated for all children enrolled in Head Start**

**Height:** _____ **ft.** _____ **in.** **Weight:** _____ **lbs.** **Vision: R** _____ **L** _____

**Blood Pressure:** _____/_____ **HCT:** _____ **Hearing: R** _____ **L** _____

**Lead:** _____ **HGB:** _____ **Passed: Yes or No (circle one)**

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1. Does the child have any allergies to any food, medications, etc.? If so, **please list and explain:**

   _____
   _____
   _____

2. Is the child currently on any medications? (or is medication needed daily) If so, **please list and explain:**

   _____
   _____
   _____

3. Is the child on a special diet and are any restrictions? If so, **please explain:**

   _____
   _____
   _____

4. Does the child have any conditions that could result in an emergency situation? If so, **please explain:**

   _____
   _____
   _____

5. Is the child developing appropriately for their age? Yes or No - **circle one**
   **Additional comments (If needed):**

   _____
   _____

6. Please list any other medical concerns for the child. **(If needed):**

   _____
   _____
   _____

**** Please attach A CURRENT COPY OF THE CHILD'S IMMUNIZATION RECORDS, along with any other immunizations given today, on this date. This is a requirement by the Office of the Head Start. ****