® Mississippi Action for Progress, Inc.

Mock Expectant Mother's Folder

Early Head Start

- **Expectant Mother's Folder Checklist**
- **Enrollment Eligibility verification for Head Start and Early Head Start programs**
- **Eligibility Selection priority criteria worksheet for early head start expectant mother applicants**
- **Expectant mother care plan**
- **Family partnership agreement**
- **Home visit report form**
- **Permission slip/release of liability enrollment intent form**

MISSISSIPPI ACTION FOR PROGRESS, INC.

Expectant Mother Folder Check List

Expectant Mother's Name: _____ Center: _____

Checked by: _____ Title: _____ Date: _____

Checked by: _____ Title: _____ Date: _____

Checked by: _____ Title: _____ Date: _____

Checked by: _____ Title: _____ Date: _____

Expectant Mother's Folder Contains the following:	Date Checked		Date Checked		Date Checked	
Form Name	Yes	No	Yes	No	Yes	No
Completed Application						
Enrollment Eligibility Verification Form						
Income Verification						
Selection Criteria						
Birth Certificate						
Social Security Card						
Proof of Insurance						
Form 121 – Immunizations						
Family Contact Logs [Child Plus]						
Physician's Statement						
Expectant Mother's Care Plan						
Family Partnership Agreement						
Letter of Enroll Intent						
Home Visits [As Needed & 2 weeks after delivery]						
Permission Slip/Release of Liability						
Other: _____						

If there are any discrepancies above, please comment: _____

_____

Observed by: _____ Date: _____

If there are any discrepancies above, please comment: _____

_____

Observed by: _____ Date: _____

If there are any discrepancies above, please comment: _____

_____

Observed by: _____ Date: _____

Region _____ Center _____ Actual Entry Date: _____

ENROLLMENT ELIGIBILITY VERIFICATION FOR HEAD START AND EARLY HEAD START PROGRAMS

Child's Name: _____

CHILD AGE AND EXPECTANT MOM DELIVERY DATE VERIFICATION*

Child's Date of Birth: _____

Child is: (____) Months [Early Head Start-EHS] - ***Enter age in months***

Child is: ☐EHS Age Eligible ☐Not EHS Age Eligible

Child is: ☐3 years old ☐4 years old [Head Start-HS] - ***Check applicable age***

Child is: ☐HS Age Eligible ☐Not HS Age Eligible

****Child age must be verified by certified or authentic birth certificate.***

Expected Delivery Date: _____

Expectant Mom is in: *(check applicable one)*

☐First Trimester ☐Second Trimester ☐Third Trimester

****Pregnancy and Expected Delivery Date must be verified by licensed physician.***

FAMILY INCOME VERIFICATION

Parent/Guardian Name: _____

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

****CHECK ALL THAT APPLY TO REPRESENT THE TOTAL INCOME OF THE FAMILY****

	Monthly	OR	Annual	Use This Space For Calculations
Public Assistance (TANF/Supplemental Security Income)	_____		_____	
Employer Verified Income	_____		_____	
Unemployment Compensation	_____		_____	
Social Security Income Benefits	_____		_____	
Pay Stubs/Pay Envelopes	_____		_____	
Child Support	_____		_____	
Income Tax Form 1040/1040A	_____		_____	
W-2 Forms	_____		_____	
Other (Specify _____)	_____		_____	
TOTAL ANNUAL FAMILY INCOME**:	$_____			

The above Annual Family Income was earned from _____Month ____Year **TO ____Month ____Year

Check here if applicable ☐**No Income ** Notarized document must accompany this Verification.**

Parent/Guardian Verification Statement: My signature below verifies that the I am the legal guardian of this child and that information given in this Eligibility Verification record is true. I understand that if any part of this Statement is determined false, my family's participation in MAP Head Start/Early Head Start Program may be terminated. I also understand that the information given in this Statement will be held in strict confidence within the Head Start/Early Head Start Program (unless my written permission is given otherwise) and is accessible to me during normal business hours.

Parent/Guardian Signature: _____ Date: _____

ELIGIBILITY DETERMINATION

Staff Verification Statement: My signature below verifies that I have examined the above named child's birth certificate and have examined the income support documents checked above and that I have not knowingly misrepresented or under-reported any information in this Eligibility Verification record . I understand that such actions may result in the termination of my employment. I also understand that copies of these documents must be attached to this Statement. The family's eligibility is noted below:
(Check applicable statement)

☐ Family is income eligible and is eligible to participate in the Head Start/Early Head Start Program.
- ☐ Below federal poverty guidelines
- ☐ Public Assistance (TANF/Supplemental Security Income) ☐Homeless ☐Foster Care

☐ Family is OVER INCOME*** as noted below and **IS** recommended for enrollment in the Head Start/Early Head Start Program. (**If recommended for enrollment, written justification must accompany this Statement)
- ☐ Between 101-130% of Poverty guidelines. Counted as part of the 10% maximum for non-AI/AN programs
- ☐ Exceeds 130% of Poverty Guidelines. Counted as part of the 10% maximum for non-AI/AN programs

☐ Family is OVER INCOME and IS NOT recommended for enrollment in the Head Start/Early Head Start Program.

Eligibility Documentation: *See 'Family Income Section of Enrollment Application-Page 1)*

Staff Signature: _____ Title: _____ Date: _____

Center Administrator Signature: _____ Date: _____

MISSISSIPPI ACTION FOR PROGRESS, INC.
JACKSON, MISSISSIPPI

ELIGIBILITY SELECTION PRIORITY CRITERIA WORKSHEET
FOR EARLY HEAD START EXPECTANT MOTHER APPLICANTS

Expectant Mother Name: _____ Expected Delivery Date: _____

Instructions: Choose one box in each category based on information from the Family Demographics Form (Sections 1-4). When appropriate, write in comments to document reason for selection. Sign form below and attach original to Family Demographics Form, forward copy to Research and Development Director in Central Office.

CATEGORY	POINTS	SELECT
AGE (select one)		
1st Trimester	20	(☐)
2nd Trimester	15	(☐)
3rd Trimester	10	(☐)
INCOME (select one)		
TANF	20	(☐)
Below Income Guidelines	15	(☐)
**Low income working or in school parent	10	(☐)
Over-Income	00	(☐)
PARENTAL STATUS (select one)		
Teen Mother	20	(☐)
One Parent	15	(☐)
Other Family Type or Relative	15	(☐)
Foster Parent	10	(☐)
Two Parent	05	(☐)
DISABILITY STATUS (select one)		
Disability diagnosed, multiple	20	(☐)
Disability diagnosed, single	15	(☐)
Disability suspected	05	(☐)
No Disability	00	(☐)
OTHER (select one)		
Homeless Family	20	(☐)
Referral from Protective Service	20	(☐)
Emergency Asst./Family Needs	15	(☐)
Referral from Other Head Start Program	10	(☐)
Referral from Other Agency or Professional	05	(☐)

*Explain details of need in **Comment Selection** below

**To be determined in central office

Total Points _____

Comments:

Signature of Staff Person Completing Form _____ Date _____

Revised for the 2010-2011 School Year

***Agency Use Only**

Mississippi Action for Progress, Inc.
Early Head Start
1751 Morson Road
Jackson, MS 39209
Phone: 601-923-4100 Fax: 601-923-0172

FCW/HV: _____ Date Initiated: _____

Demographic Information	
Expectant Mother's Name	
Date of Birth	
Address	
Telephone Number	
Emergency Contact's Name	
Emergency Contact's Address	
Emergency Contact's Telephone Number	
Place of Employment	

Prenatal History					
Do you have medical coverage?				Yes	No
Type of Coverage	Medicaid	Private Ins.	Other:		
Name of Insurance		ID/Policy #			
Have you received any prenatal care?				Yes	No
Name of Prenatal Provider					
Address of Prenatal Provider					
Telephone Number of Prenatal Provider					
When was your 1st Prenatal Visit?	Month	Day	Year		
When was your last Prenatal Visit?	Month	Day	Year		
How far along are you in your pregnancy?					
Have you received prenatal care?					
What is your expected delivery date?	Month	Day	Year		
When is your next scheduled prenatal visit?	Month	Day	Year		

Current Services [Select the services you are currently receiving and list the Provider.]			
Service	Provider	Service	Provider
Mental Health		WIC	
Substance Abuse Treatment		Other	

Support Persons [Including those to be present at delivery.]		
Name	Relationship	Comment

Medical Health Summary				
Are you presently taking any medication?			Yes	No
If yes, list.				
Do you have any special medical problems?			Yes	No
If yes, explain.				
Do you have any allergies?			Yes	No
If yes, explain				
Have you had a negative reaction to any medication?			Yes	No
If yes, explain				
Additional Medical Information				
Name of regular physician				
Address of regular physician				
Telephone number of regular physician				

Dental Health Summary				
Have you ever been examined or treated by a dentist?			Yes	No
If yes, provide name of dentist.				
Treatment provided				
Do you brush your teeth regularly?			Yes	No
If yes, explain.				
Do you have trouble with?	Teeth	Gums	Mouth	
If yes, explain				
Have you had a tooth pulled?			Yes	No
Have you ever had an accident involving the mouth?			Yes	No
Have you ever lived in an area where water supply was fluoridated?			Yes	No
Have you ever taken or are presently taking a dietary supplement?			Yes	No
Do you have any of the following habits?	Thumb Sucking	Lip Biting	Lip Sucking	Nail Biting
Name of regular dentist				
Address of regular dentist				
Telephone number of regular dentist				
Do you have dental coverage?			Yes	No
Type of Coverage	Medicaid	Private Ins.	Other:	
Name of Insurance		ID/Policy #		
When was your last Dental Visit?	Month	Day	Year	

Prenatal Visits			
Month 2 Visit Date		Month 6 Visit Date	
Month 3 Visit Date		Month 7 Visit Date	
Month 4 Visit Date		Month 8 Visit Date	
Month 5 Visit Date		Month 9 Visit Date	

Parent's Signature: _____ Date: _____

FCW Signature: _____ Date: _____

How long has it been since your last pregnancy?		
Never been pregnant	Less than 18 months	More than 18 months

Have you experienced any complications during this or any previous pregnancies?	Yes	No

Complication	Previous	Current	Complication	Previous	Current
Pain			Headaches		
Hypertension			Irritability		
Anxiety/Stress			Diabetes [Insulin Dependent]		
Pregnancy Induced Diabetes			Low Birth Weight		
Swelling			Fatigue		
Bleeding			Anemia		

Have you experienced any of the following in previous pregnancies?					Yes	No
Pre-term Labor	Month	Day	Year	Low Birth Weight	Lbs.	Oz.
C-Section	Month	Day	Year	Premature Birth [< than 35 weeks]	Yes	No
Neonatal Death	Month	Day	Year			

Have you had any complications that required bed rest?	Yes	No

If yes, what was the complication, how long were you on bed rest and date?				
Complication	How Long	Month	Day	Year

How many children have you given birth to?

Have you used any of the following during your pregnancy?					
Caffeine	Cigarettes/Tobacco	Over the counter drugs	Prescription Drugs	Alcohol	Other Drugs

Planning Ahead

Do you plan to use medication to assist with delivery?	Yes	No

What mode of pain control or anesthesia would you prefer?	General [given during sleep]		Regional [given while awake]	
	1st Choice	2nd Choice	1st Choice	2nd Choice

If necessary, would you prefer medical intervention?	Yes	No

What position do you prefer for delivery?	
Pushing efforts	
Have you discussed unexpected problems with newborn with your physician?	
If yes, what problems are foreseen?	

What method of infant feeding do you plan to use?	Breast Milk	Formula

In which areas do you require education?	Newborn Exam Procedures	Baby Care & Feeding	Infant Bathing & Hygiene	Other:

Are you planning to participate in any of the following [select all that apply].		
Prenatal Exercise	Parenting Education	Childbirth Education

Prenatal Education

Name of Training	Date	Trainer	Location
Fetal Development [Including Risks from smoking & alcohol]			
Labor & Delivery			
Breast Feeding & its Benefits			
Postpartum Recovery			
Training:			
Training:			
Training:			

Post Partum						
Delivery Date		Delivery Location				
Post Partum Visit [Two weeks after child's birth.]			Month	Day	Year	
Delivery Type	Natural	Delivery Outcome	Live Birth	Multiple Births	Other:	
	Cesarean		Stillborn	How Many		
Were there any complications?					Yes	No
If yes, please explain.						
Discharge Date						

Child(ren)'s Information					
Name		Gender	Female	Male	
Weight	lbs. ozs.	Length	inches		
Name		Gender	Female	Male	
Weight	lbs. ozs.	Length	inches		
Name		Gender	Female	Male	
Weight	lbs. ozs.	Length	inches		
Was child(ren) admitted to Neo-natal Intensive Care Unit [NICU]?				Yes	No
If yes, please explain.					
Did child(ren) die after birth?				Yes	No
If yes, please provide date and time and explain.	Date	M D Y	Time	am/pm	
Comments:					

Child(ren)'s Check-up & Results			
Check-up Date	M D Y	Results	
Check-up Date	M D Y	Results	
Check-up Date	M D Y	Results	
Check-up Date	M D Y	Results	

Immunizations Received			
Immunization	Date Received		
	Month	Day	Year

Additional Comments/Concerns

Parent's Signature: _____ Date: _____

FCW Signature: _____ Date: _____

Enrollment Date: _____

Parent/Guardian: _____

Child's Name: _____

MISSISSIPPI ACTION FOR PROGRESS, INC.
1751 MORSON ROAD – JACKSON, MS 39209
Family Partnerships

Center Name/Code: _____

Family Case Worker/Home Visitor: _____

THE _____ **FAMILY PARTNERSHIP AGREEMENT**
(Family Name)

Goal(s) to Achieve: (What would the parent like to accomplish for themselves or their family?)	**Short/Long Range Goal (1mo., 3mo., 6mo. Other)** (When will the parent/family like to have this goal achieved? Indicate a date)	**Plan of Action (Tasks/Action Steps)** (List the task/steps it will take to lead to the accomplishment of the goal.)	**Who will be Completing Task?** (Parent, Family Member, Family Case Worker, Home Visitor, Other)
1.			
2.			
3.			
4.			
Follow-up / Date (Check with parent/family **once a month** to determine status of goal attainment.)	**Type of Contact / By Whom** (Telephone, Mail, Office, Home Visit)	**Additional Notes:**	**Goal Completion Date** (Indicate the date the goal was achieved.)

FAMILY MEMBER SIGNATURE: _____
Parent/Guardian to sign at the time the goal is developed.

DATE: _____
(Date when the goal is developed.)

_____
Family Case Worker/Date

FCP/May 2010

GROWING STRONG

MIHOW

Maternal Infant Health Outreach Worker

HOME VISIT REPORT FORM

Participant's Name _____

Date _____ **Home Visit #** _____

Visit Plan: (To be completed before visit.)

1) What objectives do you plan to discuss with the participant?

2) Did she have concerns or issues from the last visit that need reviewing this time?

Description of Visit:

1) What objectives and activities did you address?

2) What issues did she seem particularly excited about?

Home Environment:

1) Who was present during this visit?

2) What is happening in the family that might affect or be affected by the pregnancy/child?

Follow-up for Next Visit:

1) Special concerns

2) Plans for next visit

3) Questions/topics to research for mother

Signature of Pregnant Woman	**Date**	**Signature of Case Worker**	**Date**

White Copy: Pregnant Woman
Yellow Copy: Agency Files

MISSISSIPPI ACTION FOR PROGRESS, INC

EXPECTANT MOTHER PROGRAM

PERMISSION SLIP / RELEASE OF LIABILITY
ENROLLMENT INTENT FORM

Please initial the following statements to indicate your agreement:

_____ 1. After delivery, my child WILL participate in the Mississippi Action for Progress, Inc. Early Head Start program.

_____ 2. I hereby agree to participate in the Mississippi Action for Progress Expectant Mother program. I have been advised of the purpose of this program and I am in full support of the program. I give Mississippi Action for Progress my permission to use my likeness, name, voice or words in either television, radio, film, newspaper, magazines or other media, and in any form for the purpose of advertising or communicating the activities of the Expectant Mother program.

_____ 3. I also release Mississippi Action for Progress from any and all liabilities associated with project activities. If during my participation in project activities, I should need emergency medical treatments and I am not able to give my consent to make my own arrangements for treatment, I authorize Mississippi Action for Progress to take whatever measures are necessary to protect my health and well-being including, if necessary, hospitalization.

_____ _____

Participant's Signature Date

_____ _____

Witnessing Staff's Signature Date

MAP 10/2003