® Mississippi Action for Progress, Inc.

Comprehensive Folder

Early and Head Start

- **Folder setup – section 1: enrollment**
- **Early Head Start Applicant & family member information**
- **Head Start Applicant & family member information**
- **Enrollment eligibility verification for early start and head start programs**
- **Proof of income**
- **Birth certificate**
- **Over-income child approval form**
- **Selection criteria worksheet**
- **Eligibility selection priority criteria worksheet for early & head start expectant mother applicants**
- **Eligibility selection priority criteria worksheet for early & head start expectant children applicants**
- **Social Security Card**
- **Change of status request**
- **Re-enrollment intent statement**

MISSISSIPPI ACTION FOR PROGRESS, INC.

Folder Setup – Section I: Enrollment

This section should contain:

( ) Enrollment Application
- ( ) Parent Signature
- ( ) Staff Signature

( ) Enrollment Eligibility Verification Form
- ( ) Parent Signature
- ( ) Staff Signature
- ( ) Center Administrator Signature
- ( ) Enrollment Date Noted

( ) Proof of Income

( ) Birth Certificate

( ) Over-Income Child Approval Letter (for over-income families only)

( ) Selection Criteria Worksheet
- ( ) Staff Signature

( ) Social Security Card

( ) Change of Status Form (if any)
- ( ) Parent Signature
- ( ) Staff Signature

( ) Waiting list or Returning Child Intent Form (if applicable)

Reviewed By:

_____	_____
Name/Position	Date
_____	_____
Name/Position	Date
_____	_____
Name/Position	Date
_____	_____
Name/Position	Date

Comments/Suggestions:

_____

_____

_____

_____

Revised August 2012

ChildPlus Family ID # _____

Mississippi Action for Progress, Inc.

EARLY HEAD START

Application # _____

Applicant & Family Member Information

Primary Adult Name _____ SSN _____ Birthday _____

Applicant Name _____ SSN _____ Birthday _____

Applicant *(Child Applying for Services)*

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Ethnicity

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Primary Health Coverage | Other Health Coverage | Insurance # | Medicaid | Medicaid # | Doctor | Dentist

Medicaid
☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible

Adult 1

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Ethnicity

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed | Employment Status

E-mail Address

Relationship
☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent
If teen parent, subsidized? ☐ Yes ☐ No

Adult 2

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Ethnicity

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed | Employment Status

E-mail Address

Relationship
☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent
If teen parent, subsidized? ☐ Yes ☐ No

Additional Child *- Is this child also applying for services?* ☐ Yes ☐ No

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian
☐ Black
☐ White
☐ Other: _____

Ethnicity
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Multi-Racial

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Additional Child *- Is this child also applying for services?* ☐ Yes ☐ No

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian
☐ Black
☐ White
☐ Other: _____

Ethnicity
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Multi-Racial

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

ChildPlus Family ID # _____

Mississippi Action for Progress, Inc.

HEAD START

Application # _____

Applicant & Family Member Information

Primary Adult Name _____ SSN _____ Birthday _____

Applicant Name _____ SSN _____ Birthday _____

Applicant *(Child Applying for Services)*

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Ethnicity

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Primary Health Coverage | Other Health Coverage | Insurance # | Medicaid | Medicaid # | Doctor | Dentist

Medicaid
☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible

Adult 1

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Ethnicity

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed | Employment Status

E-mail Address

Relationship
☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent
If teen parent, subsidized? ☐ Yes ☐ No

Adult 2

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Ethnicity

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed | Employment Status

E-mail Address

Relationship
☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent
If teen parent, subsidized? ☐ Yes ☐ No

Additional Child *- Is this child also applying for services?* ☐ Yes ☐ No

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian
☐ Black
☐ White
☐ Other: _____

Ethnicity
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Multi-Racial

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Additional Child *- Is this child also applying for services?* ☐ Yes ☐ No

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian
☐ Black
☐ White
☐ Other: _____

Ethnicity
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Multi-Racial

English Proficiency
☐ None ☐ Little ☐ Moderate ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

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: _____

PROOF OF INCOME

BIRTH CERTIFICATE

Mississippi Action for Progress
Office of Research and Development
1751 Morson Road
Jackson, MS 39209

DATE: April 3, 2013

TO: Regional Manager
Center Administration

FROM: Dr. Peggy S. Johnson, Director of Research and Development
Ms. Malika Griffin, Enrollment Coordinator

RE: Over- Income Child Approval (Child's Name)

The following child, **has been approved for the ENROLLMENT at the Head Start Center as an over income child.**

This office will inform you of USDA required documentation when available. Please be reminded that all over income children must have an approval letter on file prior to the child's entry into the center.

Name	Priority Points	Application Date	Approval Date	Income Status

Justification:

If you have any question please do not hesitate to call (601) 923- 1936.

Thank you in advance for your time and consideration.

MISSISSIPPI ACTION FOR PROGRESS, INC.
JACKSON, MISSISSIPPI

SELECTION CRITERIA WORKSHEET

Child's Name: _____ Birthday: _____ Center: _____

Instructions: Check one box in each area based on information from the Application for Enrollment. When appropriate, write in comments to document reason for selection. Sign form below and attach to Application for Enrollment.

AREA	CATEGORY	POINTS	SELECT
AGE (select one)			
4 years old this school year	FOUR	25	(☐)
3 years old this school year	THREE	15	(☐)
INCOME/CATEGORICALLY ELIGIBLE (select one)			
Homeless		50	(☐)
Foster Care		50	(☐)
Public Assistance (TANF/Supplemental Security Income)		50	(☐)
Below Income Guidelines		25	(☐)
**Working low income between 101-130%		05	(☐)
Over-income		00	(☐)
PARENTAL STATUS (select one)			
Single Parent	ONE	25	(☐)
Other Family Type or Relative(s)	OTHER	15	(☐)
Two Parent	TWO	05	(☐)
DISABILITY STATUS (select one)			
Disability diagnosed, multiple	DMULT	25	(☐)
Disability diagnosed, single	DSING	20	(☐)
*Disability suspected	SUSP	05	(☐)
No Disability	NONE	00	(☐)
OTHER (select one)			
Transition from Early Head Start (MAP)		25	(☐)
*Referral from Protective Service/Emerg. Asst.	PSREF	15	(☐)
*Referral from Other Agency or Professional	OTREF	05	(☐)
	Total Points	_____	

**To be determined by Central Office.
Comments: (*Explain details of need in **Comment Section** below)

Signature of Staff Person Completing Form _____ Date _____
Revised for the 2012-2013 School Year
***Agency Use Only**

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	25	(☐)
2nd Trimester	15	(☐)
3rd Trimester	10	(☐)
INCOME/CATEGORICALLY ELIGIBLE (select one)		
Homeless	50	(☐)
Foster Care	50	(☐)
Public Assistance (TANF/Supplemental Security Income)	50	(☐)
Below Income Guidelines	25	(☐)
**Working low income between 101-130%	05	(☐)
Over-income	00	(☐)
PARENTAL STATUS (select one)		
Teen Mother	25	(☐)
One Parent	15	(☐)
Other Family Type or Relative	15	(☐)
Two Parent	05	(☐)
DISABILITY STATUS (select one)		
Disability diagnosed, multiple	25	(☐)
Disability diagnosed, single	20	(☐)
Disability suspected	05	(☐)
No Disability	00	(☐)
OTHER (select one)		
Referral from Protective Service	25	(☐)
Emergency Asst./Family Needs	15	(☐)
Referral from Other Agency or Professional	05	(☐)

Total Points _____

**To be determined in Central Office
Comments: (*Explain details of need in **Comment Section** below)

Signature of Staff Person Completing Form _____ Date _____
Revised for the 2012-2013 School Year
***Agency Use Only**

MISSISSIPPI ACTION FOR PROGRESS, INC.
JACKSON, MISSISSIPPI

ELIGIBILITY SELECTION PRIORITY CRITERIA WORKSHEET
FOR EARLY HEAD START ELIGIBLE CHILDREN APPLICANTS

Child's Name: _____ Date of Birth_____ Age: _____

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)		
6 wks. – 6 months	25	(☐)
7-11 months	15	(☐)
12-18 months	10	(☐)
19-24 months	05	(☐)
25-36 months	04	(☐)
INCOME/CATEGORICALLY ELIGIBLE (select one)		
Homeless	50	(☐)
Foster Care	50	(☐)
Public Assistance (TANF/Supplemental Security Income)	50	(☐)
Below Income Guidelines	25	(☐)
**Working low income between 101-130%	05	(☐)
Over-income	00	(☐)
PARENTAL STATUS (select one)		
Teen Mother	25	(☐)
One Parent	15	(☐)
Other Family Type or Relative	15	(☐)
Two Parent	05	(☐)
DISABILITY STATUS (select one)		
Disability diagnosed, multiple	25	(☐)
Disability diagnosed, single	20	(☐)
Disability suspected	05	(☐)
No Disability	00	(☐)
OTHER (select one)		
Referral from Protective Service	25	(☐)
*Referral from Other Head Start Program	10	(☐)
*Referral from Other Agency or Professional	05	(☐)

Total Points _____

**To be determined by Central Office
Comments: (*Explain details of need in **Comment Section** below)

_____

_____

Signature of Staff Person Completing Form _____ Date _____
Revised for the 2012-2013 School Year
***Agency Use Only**

SOCIAL SECURITY CARD

CHANGE OF STATUS REQUEST

Center Name: _____ Center Code: _____

Child's Full Name: _____ Child's Record ID#: _____

Parent(s) / Guardian Name: _____

WAITING LIST – DROP

Effective Drop Date : ____/____/____

Reason: _____

_____

_____

ADDRESS/PHONE CHANGE

Old Address: _____

New Address: _____

Old Phone # (H/M/O): _____

New Phone# (H/M/O): _____

CLASS ROLL – DROP

Effective Drop Date: ____/____/____Unit #: _____

Reason: _____

_____

Last Day Attended: ____/____/____

NOTICE: Only during the time of termination and with a *written* parent approval, the child can be in "Term/Wait" status. (Attach approval at the time of request)

CUSTODY CHANGE*

[ ] Foster [ ] Natural [ ] Other

New Family Name: _____

Effective Date: _____

UNIT TRANSFER

Transfer From: Unit # _____ To: Unit # _____

Effective Transfer Date: ____/____/____

NAME CHANGE*

Change Name To: _____

Change Parent To: _____

Effective Date: ____/____/____

CENTER TRANSFER

Transfer From: _____ Center

Effective Transfer Date: ____/____/____

Transfer To: _____ Center

Receiving C.A. Signature: _____

Transferring To Unit # _____

MEDICAID/INSURANCE CHANGE

Medicaid Number: _____

Medicaid Add Date: _____

Medicaid Drop Date: _____

Insurance Policy #: _____

FAMILY STATUS CHANGE

Previous Number In Family: _____

Previous Family Income: $_____

New Number In Family: _____

New Family Income: $ _____

BIRTH RECORD CHANGE

Birth Certificate #: _____

Legal Birth State: _____

Reason For Change: _____

_____

Other (specify) _____

_____

_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** ____/____/____

FAMILY SERVICES WORKER SIGNATURE: _____ **DATE:** ____/____/____

CENTER ADMINISTRATOR SIGNATURE: _____ **DATE:** ____/____/____

REGIONAL MANAGER SIGNATURE: _____ **DATE:** ____/____/____

ENROLLMENT COORD/RESEARCH STAFF SIGNATURE: ** _____ **DATE:** ____/____/____

***Legal Document Must Be Attached**

****Required for Enrollment and Waiting List Status Changes**

MISSISSIPPI ACTION FOR PROGRESS, INC.

3-TOOMSUBA CENTER
6836 LAUDERDALE TOOMSUBA RD.
TOOMSUBA , MS 39364-

Jan 17, 2012

Dear LARSON Family,

Mississippi Action for Progress, Inc. is beginning recruitment and enrollment activities for the 2012 - 2013 School Year by verifying and re-enrolling children currently enrolled in Head Start who will be returning tentatively on Monday ***August 20, 2012***.

Please assist us in this process by completing the **RE-ENROLLMENT INTENT STATEMENT** below and returning it to 3-TOOMSUBA CENTER no later than Wednesday, February 29, 2012. Centers will schedule a one (1) week Registration Fair for parents to re-enroll children.

We appreciate your continued support of our Head Start Program at 3-TOOMSUBA CENTER. It will greatly assist us in developing your child's health program if you provided a copy of your child's most recent medical evaluation. Please contact your local Center at (601) 632-4491 to complete the re-enrollment process or if you need assistance.

Sincerely,

Dr. Peggy S. Johnson

Dr. Peggy S. Johnson
Director of Research Development

RE-ENROLLMENT STATEMENT

3-TOOMSUBA CENTER **:Center**

Child's Name: _____ Child's SSN: _____

[✓] My child WILL be returning to Head Start on August 20, 2012.
[ ] My child WILL NOT be returning to Head Start on August 20, 2012.
[ ] Has your income status changed: [ ] Yes [✓] No Family Income $._____
My current mailing address is:

Parent/Guardian Signature: _____ Date: _____