Iowa Tribe of Oklahoma Expectant Families Program Enrollment Information FY 2023-2024

Expectant Mother,

Thank you for your interest in the Iowa Tribe of Oklahoma Early Head Start Expectant Families Program. In order for us to determine your eligibility we need the following information.

- ☐ Application (pages 1-3 completed and signed)
- ☐ Proof of income for each adult member of your family. Submit ONE of the following: If applicant is a teen and not working, skip to the next section.
  - Recent income for a month period
  - Income tax statement
  - Public Assistance award letter for TANF or SNAP
  - Verification of wages signed by employer
  - SSI
- ☐ Copy of Insurance Card
  - Medicaid
  - United Health Care
  - Blue Cross Blue Shield
  - Other
- ☐ CDIB (if applicable)

*Above documents must be submitted before your application can be evaluated. Please submit copies only.

We look forward to receiving your application! You can either mail or deliver your documents by using the information below. If you have any questions or need assistance contact Carrie Drennan at 405-547-2402 x5003.

Deliver application to:

Iowa Tribe Child Development Center (next to Iowa Tribe Fire Station)

@ Mail application to:

Attn: Iowa Tribe of Oklahoma
335588 E. 750 Rd
Perkins, OK 74059

Iowa Tribe of Oklahoma
Early Head Start

Expectant Families Program
Application for Enrollment

Date _____ How did you find out about our program? _____

Family Information

Expectant Mother _____ Phone _____
Birth Date (Month/Day/Year)_____ Email _____
Physical Address _____City_____ Zip _____
Mailing Address _____City_____ Zip _____

Race _____ Language(s) Spoken_____
CDIB ☐ Yes ☐ No If yes, list tribe_____
Employer/School_____
Active Military Member: ☐Yes ☐No

Expectant Father _____ Phone _____
Birth Date (Month/Day/Year)_____ Email_____
Physical Address _____City_____ Zip _____
Mailing Address _____City_____ Zip _____

Race _____ Language(s) Spoken _____
CDIB ☐ Yes ☐ No If yes, list tribe_____
Employer/School_____
Active Military Member: ☐Yes ☐No

☐ One-Parent Family ☐ Two-Parent Family ☐ Teenage Mother

Number in Household (including baby) _____ Marital Status _____

Prenatal Information

What week of pregnancy? _____ What is your expected due date? _____

Any complications with your current pregnancy? ☐ Yes ☐ No
If yes, describe _____

Any complications with previous pregnancies? ☐ Yes ☐ No
If yes, describe _____

Do you have a prenatal provider (doctor for your pregnancy)? ☐ Yes ☐ No
Name_____Address_____
Phone_____ Date of last visit_____

Income Information

Does your family receive any of the following services or assistance?

☐TANF	☐Child Support	☐SSI	☐WIC
☐Housing Assistance	☐Child care assistance	☐Sooner Care	☐Unemployment
☐Food Stamps	☐Social Services financial assistance		☐Foster care

☐Other_____

Family's Gross Income (include SSI if applicable):

Weekly $ _____ Or Monthly $_____ Or Yearly $_____

Enrollment Priority is given to eligible families who have special circumstances. Please check any circumstances that apply to your family.

Family

___ Diagnosed Disability, if yes list_____
___ Suspected Disability, if yes list_____
___ Teen Pregnancy
___ Medical Concerns
___ Nutritional Concerns
___ English as Second Language
___ Single Parent (in school or working)
___ Blended Family
___ Unemployed
___ Limited Resources
___ Recent Divorce or Separation
___ Deceased Parent
___ Domestic Violence
___ Substance Abuse
___ Homelessness
___ Major Change in Family
___ Home Safety Hazards
___ Other, explain_____

Current and Previous Pregnancies (please check all that apply)

Complications	Current Pregnancy	Previous Pregnancy
Pain		
Bleeding		
C-Section		
Fatigue		
Pre-Term Labor		
Diabetes		
Pregnancy Induced Diabetes		
Anemia		
Headaches		
Swelling		
Sickle Cell		
Hypertension		
Pregnancy Induced Hypertension		
Neonatal Death		
Miscarriage		
Bed Rest		
Hospitalization		
Other, list _____		

Signature of Applicant _____ Date _____

Consent for the Release of Confidential Information

Expectant Mother	Date of Birth	Social Security #

I authorize, Community Health Nurse,
Iowa Tribe of Oklahoma/Early Head Start Expectant Families Program
335588 E. 750 Rd. Perkins, OK 74059

Release to: _____
Your Prenatal Provider's Name

Information: Name and date of birth for program planning and completion of the Health Evaluation. I also authorize my prenatal provider to respond by completing the Health Evaluation provided.

I understand these records are protected and confidential and cannot be released without written consent. Expectant Families Program does not disclose any information without a written consent. I also understand I may cancel this consent in writing at any time unless action has already been taken based upon this consent.

_____
Expectant Mother Signature

_____
Date

(Consent expires after one year)

Iowa Tribe of Oklahoma Early Head Start & Expectant Families Program

Child/Family Housing Questionnaire

Your child may be eligible for additional services. Eligibility can be determined by completing this questionnaire.

1. Where are you and your family currently staying? *Check one box*
   - ❑ Sharing the housing of another family (i.e., doubling-up) due to loss of housing, economic hardship or similar reason.
   - ❑ Living in a motel, hotel, trailer park, or campground because we cannot afford or find affordable housing.
   - ❑ Staying in an emergency or transitional shelter.
   - ❑ Living in a vehicle of any kind; in an abandoned building, in a tent, or campground or substandard housing without running water/electricity; or in a park, bus or train station.
   - ❑ Section 8 Housing
   - ❑ Military Housing
   - ❑ None of the above. Living in my own apartment/home that I rent or own.
2. Please check all the apply.
   - ❑ Child is living with an adult that is not a parent or legal guardian.
   - ❑ Child is awaiting foster care placement.
   - ❑ None of the above. Child is my own child.
3. Please describe the child who "lacks a fixed, regular, and adequate nighttime residence."

Name of Child(ren) **First** **Middle** **Last**	**Male/Female**	**Date of Birth**

The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name/Adult Caring For Child Signature Date

Address (if available) City State Zip Code

(Area Code) Phone Number (Your own or a family member/friend's through which we can reach you)

● ●

Head Start Use Only

EHS ERSEA: Based on the above information (where one or none of the *"None of the Above"* boxes are checked) and a brief interview with this family, I attest that to the best of my knowledge by the information provided to me the child is eligible for benefits.

____

Print ERSEA Signature **Date**

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