Additional Information for Applicants

Add Participation Record for: _____

Program Term Required	Agency Required	Initial Status Required

Status Begin Required	

Location Preferences

Priority	Site	Classroom	Funding

Priority	Site	Classroom	Funding

Enrollment Information

Enrollment

Eligibility

Application Date	Application Status	Participation Year PIR	CACFP Status	Eligible to Participate	Interview Type	Income Status
				☐ Yes ☐ No		

Eligibility Date	Number in family	Eligibility Income	Income adjusted for excessive housing costs PIR	Documentation Used	Documentation of no income

Selection Criteria

Parental Status	Diagnosed Disability	Risk Factors

Pregnant Mother	Returning	Adjustment
☐ Yes ☐ No		

Health

Health Information

Doctor	Dentist

PIR Health Coverage

Primary health coverage at enrollment PIR	Medicaid Eligibility	Medicaid Number
☐ Private insurance ☐ Combined Medicaid ☐ CHIP ☐ No insurance ☐ Other: _____ ☐ Medicaid	☐ Not eligible ☐ On Medicaid ☐ Potentially eligible	

Dental Coverage	Dental coverage number	Insurance Number
☐ Private insurance ☐ Combined Medicaid ☐ CHIP ☐ No insurance ☐ Other: _____ ☐ Medicaid		

Immunizations

Family Services

Homeless Family PIR	Referred by welfare agency PIR	Military service – Active duty at enrollment PIR
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Public Assistance	TANF PIR	SSI PIR	WIC PIR	SNAP PIR	WIC ID
At Enrollment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
At end of enrollment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Eligibility Criteria (Circle all that apply.)

Eligibility Question	Possible Answers	Points
Sibling currently enrolled in EHS/HS	YES NO	**********
Transitioning Student	YES NO	**********
Disability/IEP/IFSP	Suspected Disability/Parent Concern or Documented Disability	**********
Health/Mental Health Concern	Heart condition, seizures, diabetic, food allergies, asthma, other.	**********
Behavior/Social/Emotional	Example:	**********
At Risk Factors	CPS/ICW, incarceration/probation/parole, substance abuse, death, transportation, unemployment, other.	**********
Expected Parent	YES NO	**********

Staff Eligibility Verification Signature: _____ Date:_____

Zero Income Statement for School Year 2026-2027

This statement is to certify that I am not receiving income from any source whatsoever.

___ I am not employed through any private or public employer.

___ I am not receiving unemployment compensation benefits.

___ I am not receiving Social Security benefits or any type of annuity benefits.

___ I am not receiving Temporary Disability Assistance Payments for Adults, Temporary Cash Assistance, or Pension or Veteran's Benefits.

If more than one adult in the household is claiming "zero income" you will need to provide a signed copy of this form for each adult member.

If your total family income is "0" and has been for at least one (1) month prior to the date of this application, please explain how you are meeting your living expenses.

⇒ How do you pay for your housing/utilities?

⇒ How do you pay for clothing?

⇒ How do you pay for transportation?

I understand that in signing this form I am knowingly and willingly reporting that I have a "zero income" household. I also understand that by signing this form I am not reporting any false or fraudulent information.

I certify that this information is true, complete, and correct.

_____

Parent/Guardian Signature Date

_____

Family Services Signature Date

Authorization to Release and Obtain Information

2899 Highway 47 * Lac du Flambeau * WI * 54538 * (715)588-9291 * FAX: (715)588-9576

Name of Child_____ **Date of birth**_____

Name of Parent_____ **Date of birth**_____

SNAP as Public Assistance for Head Start Eligibility

***Families eligible for or receiving benefits from SNAP (FoodShare) and FDPIR (Food Distribution Program on Indian Reservations) will be included in categorical eligibility for Head Start services.

The Administration for Children and Families (ACF) strives to ensure that programs minimize the burden on families seeking public assistance and to coordinate benefit programs in such a way that families who are eligible for one benefit program can more easily participate in other services for which they are eligible. ACF issued an Information Memorandum (IM) to set forth its interpretation of the phrase "public assistance" in Sec. 645 of the Head Start Act to include the Supplemental Nutrition Assistance Program (SNAP). Adopting this interpretation will make it easier for eligible families to enroll children in Head Start services by allowing families to demonstrate proof of SNAP receipt or eligibility to enroll in Head Start and will simplify the process of determining program eligibility for grantees. For the purposes of Head Start eligibility determination, the Office of Head Start (OHS) will expand its interpretation of "public assistance," as used in the Head Start statute, to include SNAP and FDPIR.

Economic Support Agency PO Box 67, Lac du Flambeau, WI 54538

- ☐ SNAP/FoodShare verification

Food Distribution Program PO Box 67, Lac du Flambeau, WI 54538

- ☐ Food Distribution verification

_____ ____/_____/_____

Signature of Parent/Guardian Date

Parent/Guardian Authorization/Permission

This authorization is valid for SY 26-27 (expires August 31, 2027). I understand that I may revoke this authorization at any time by submitting written notice of withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release the information.

Families who only received P-EBT benefits will not count as public assistance for Head Start categorical eligibility.

Home Phone: Cell Phone: Email:	Zaasijiwan Head Start **EMERGENCY CARD**
Student Name: (Last Name, First Name)	(Circle One) Birth Date: (Circle One) M F _____/_____/_____ EHS/HS
Height: Weight: Hair Color: Eye Color:	Lives with: (Choose One) □ Both Parents □ Mother Only □ Father Only □ Other OTHER/Name: Relationship to Student: Any legal documents regarding guardianship? YES NO
Child's Physical Address:	City/State/Zip
Mailing Address:	City/State/Zip
Father's Name/Day Phone #	Father's Employer with Phone #
Mother's Name/Day Phone #	Mother's Employer with Phone #

Was child born 3 or more weeks premature? If yes, how many weeks?

Did your child ever have or does your child now have:

Yes	No	Check Each Item	Yes	No	Check Each Item	Yes	No	Check Each Item
		Allergies			Physical Disability			Frequent Headaches
		Arthritis			Eye Glasses/Contacts			Heart Condition
		Asthma			Epilepsy/Seizures			Meningitis
		Bedwetting			Frequent Earaches			Kidney Problems
		Bone, joint, or muscle problems			Frequent colds or sore throats			Excessive gain or loss of weight
		Chickenpox			Frequent Stomach Aches			Skins Problems
		Diabetes			Hay Fever			Tuberculosis
		Attention Deficit Disorders (ADD)			Emotional problems or depression			Tumors, growths, cysts, cancer
		Hearing Problems			ENTER DATE OF LAST TETANUS SHOT: _____/_____/_____			

Are there any other health problems or family matters that would be helpful for the school nurse to know about? NO YES,Explain Please

Check each item YES or NO. Every item checked YES must be fully explained at right.

YES	NO		EXPLANATION
		Does the child take routine medication? If yes, give type, amount, and reason.	
		Do you know of any reason to limit your child's physical activities?	
		Has your child had any severe reactions or allergies to drugs, foods, bites or stings?	
		Any special emergency instructions?	**Please call and speak with the school nurse at 588-9291.**

It is my understanding that if emergency treatment is required and I cannot be reached, school authorities may assume responsibility of notifying the doctor indicated and/or Emergency Medical Services unless I have provided written notice to the contrary to the program director.

DOCTOR AND/OR CLINIC NAME:	Phone number:
Signature of Parent/Guardian:	Date Signed:

OMB Control No. 1810-0021 (Exp. 08/31/2027)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School_____ School District_____

Tribal Membership

The individual with Tribal membership is the (select only one): ___child ___child's parent ___ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ☐ Federally Recognized Tribe
- ☐ State Recognized Tribe
- ☐ Terminated Tribe
- ☐ Alaska Native
- ☐ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

Membership or enrollment number establishing membership _____ (if readily available) or other evidence establishing membership in the Tribe listed above _____ (describe and attach).

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature_____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email_____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

Authorization to Screen, Obtain, and Release Information

2899 Highway 47 • Lac du Flambeau • WI 54538 • 715-588-9291 Fax 715-588-9576

Name of Child _____ Date of Birth ___/___/_____

HIPPA – Compliant authorization to screen, obtain, exchange, or release health, education information and/or use of child's photograph/video for ZHS activities:

Zaasijiwan Head Start 0 to 5 Program PO Box 67, Lac du Flambeau, WI 54538

- ☐ Health/Oral Health Screening and Results
- ☐ Mental Health and Developmental Screening and Results
- ☐ Other _____

Peter Christensen Health Center PO Box 67, Lac du Flambeau, WI 54538

- ☐ Health Records and Examination Results
- ☐ All Screening/Rescreening and Results
- ☐ Referral follow-up
- ☐ Other _____

Peter Christensen Dental Clinic PO Box 128, Lac du Flambeau, WI 54538

- ☐ Dental Screening and Results
- ☐ Dental Examination/Treatment and Results
- ☐ Referral/follow-up
- ☐ Other _____

Marshfield Clinic – Minocqua Center and FHC 9601 Towline Road, Minocqua, WI 54548

- ☐ Health Records and Examination Results
- ☐ Immunization records
- ☐ Referral follow-up
- ☐ All Screening/Rescreening and Results
- ☐ Other _____

Aspirus Health 240 Maple Street, Woodruff, WI 54568

- ☐ Health Records and Examination Results
- ☐ Immunization records
- ☐ All Screening/Rescreening and Results
- ☐ Other _____

Human Service Center (Birth to Three) 705 E Timber Drive, Rhinelander, WI 54501

- ☐ Developmental screening and results
- ☐ Individual Family Service Plans (IFSP)
- ☐ Referral follow-up
- ☐ Other _____

Lac du Flambeau Public School 2899 Highway 47, Lac du Flambeau, WI 54538

- ☐ All official student records and reports
- ☐ Individualized education plans (IEP) and related reports
- ☐ All Health Records and Screening Results
- ☐ Other _____

Family Resource Center PO Box 67, Lac du Flambeau, WI 54538

- ☐ Psychological observation reports
- ☐ Referral follow-up
- ☐ Behavioral observations
- ☐ Other _____

Family Services PO Box 67, Lac du Flambeau, WI 54538

- ☐ Guardianship/Custodial/Placement Documents
- ☐ Referral follow-up
- ☐ Other _____

Parental / Guardian Authorization/Permission

This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. This authorization also gives permission for ZHS and community care partners to perform required screenings and observations of participants. I recognize that these records, once received by the agency, may not be protected by the HIPPA Privacy Act and may become educational records protected by the Family Educational Rights and Privacy Act-FERPA with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to participate in this program. I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the information I have authorized to be used or disclosed by this authorization form. Arrangements to inspect this information can be made by contacting the Zaasijiwan Head Start-ZHS Director.

_____/_____/_____

Signature of Parent or Guardian **Date**

(Fax or photocopy effective as original)(Copies to parent/guardian, physician or other health care provider releasing the protected health information, school official requesting/receiving the protected health information, student SpEd file. Information also to be used to maintain heath status record for participants in a Federal program.)

May 2024 revised