Inyo Mono Advocates for Community Action, Inc. (IMACA)

THIS FORM MUST BE COMPLETED

Client Intake Form

IMACA CSBG(Rev. 1/12) Shaded Areas for Official Use Only

Service Codes			
Priority Points			

Agency Location:	**Intake Staff:**	**Intake Date:**

1 First Name of Child	Middle Initial	Last Name	Sex	Age	Date of Birth

Street Address	Unit #	City	County	State	Zip Code
				CA	

Mailing Address (if different than above) **P.O. Box**	City	County	State	ZIP Code

Phone Number- 1	Phone Number- 2		Family Size (adults that take responsibility for the children and all children under 18 years old.)

Household Member Information

	Names of All Other Family Members	Sex	Date of Birth	Age	Relationship to Child	Ethnicity/ Race (Hispanic/ Not Hisp, Caucasian, Black, Asian, Native, Multi-Race, other)	Education (0-8 Grade, 9-12, HS Graduate, GED, Some Secondary, College Degree)	Other Characteristics (Disabled, Health Insurance, Migrant/ Farm/ Seasonal Worker, Veteran)
P								
P								
S								
S								
S								
S								
S								

Household Information

Housing *(check all that apply to your household)*

A. ☐ **Own**
B. ☐ Rent
C. ☐ Homeless
D. ☐ Subsized/ Public Housing
E. ☐ Mobile Home
F. ☐ Apartment/Duplex
G. ☐ Single Family Home

Family Type *(check one)*

A. ○ Single Parent- Female
B. ○ Single Parent-Male
C. ○ 2-Parent Household
D. ○ Single Person
E. ○ 2 Adults, No Children
F. ○ Teen Parent (under 20)
G. ○ Single Teen Parent (under 20)
H. ○ Other:_____

I am Interested in More Information About: *(check all that apply)*

A. ☐ Food Assistance
B. ☐ Energy Assistance
C. ☐ Weatherization
D. ☐ Youth or Adult Conservation Corps
E. ☐ Holiday Food Baskets/ Gifts Program
F. ☐ Child Care Subsidy/ Community Connections for Children (Mono County)
G. ☐ Head Start/ State Preschool
H. ☐ Housing Assistance
I. ☐ Garden Assistance
J. ☐ Volunteering with IMACA
K. ☐ Other

Household Income Sources

Enter total GROSS (before taxes) monthly income for all persons living in the household:

CashAid/ TANF	$	
SSI/SSP	$	
Social Security	$	
Pension	$	
General Assistance	$	
Unemployment	$	
Veterans Benefits	$	
Child Support	$	
1 - Employment	$	
2 - Employment	$	
3 - Employment	$	
4 - Employment	$	
OTHER	$	
Total Monthly Income	$	
Annual Income	$	
Percentage of Poverty Level		**%**

Applicants Statement: The information on this application will be used to determine and verify my eligibility for assistance with any IMACA program. I also understand that IMACA does not discriminate in the provision of services on the basis of race, color, national origin, disability, age, or sex. I certify that the information I have given is correct and is not provided with the intent to defraud and I am aware that any deliberate falsification of information will be grounds for immediate dismissal from any IMACA program. I hereby acknowledge that the information relating to the determination of my eligibility requires verification and/or documentation, and that by my signature I authorize all parties, whether agencies or individuals, to release any and all such information.

Applicant's Signature _____ Date _____ Witness' Signature **(if signed with an X)** _____

Turn over →

IMACA

Head Start/State Preschool

2012 Intake Survey

Child You Are Requesting Services For: _____

Does Your Child Have an IFSP or IEP (referred to services for learning or speech delay) ☐ NO ☐ Yes If yes, who provides services?

Does he/she have a chronic condition such as Asthma or require medication? ☐ NO ☐ Yes, please explain below.

Does your child have any allergies (food, medication, inhaled, skin contact, insect)? ☐ NO ☐ Yes, please explain below.

Which Head Start/ State Preschool center would you like your child to attend?

☐ Lone Pine ☐ Clarke St, Bishop ☐ Little Promises, Bishop ☐ Mammoth Lakes ☐ Lee Vining ☐ Coleville, State Preschool only

Reason? _____ Did this child attend our program last year: ☐ NO ☐ Yes

How did you learn about Head Start / State Preschool?

- ☐ Sibling who attended (Name: _____)
- ☐ From a friend or relative
- ☐ From a sign or advertisement
- ☐ At Elementary School
- ☐ Referred by: _____
- ☐ Community Agency: _____
- ☐ Community Event: _____
- ☐ Other: _____

Does this child have health insurance?	***Does this child have dental insurance?***
☐ NO ☐ YES, please indicate:	☐ NO ☐ YES, please indicate:
☐ MEDI-CAL ID# _____	☐ MEDI-CAL ID# _____
☐ HEALTHY FAM. ID# _____	☐ HEALTHY FAM. ID# _____
☐ PRIVATE INS. ID# _____	☐ PRIVATE INS. ID# _____
Carrier: _____	Carrier: _____
Physician's Name/ Address:	***Dentist's Name/ Address:***
	Fax:

Do you collect any of the following services? ☐ WIC ☐ Food Stamps (SNAP)

☐ Cash Aid, CALWORKS ☐ TANF ☐ SSI/ Disability Income ☐ Survivor Benefits ☐ Child Support ☐ Unemployment

If you receive Public Assistance, write your case # and social worker's name: _____

If you receive WIC, please write your ID#: _____

Which languages are spoken in your home? Mark all that apply.

☐ English ☐ Spanish ☐ OTHER: _____

What language do you prefer to be contacted in from IMACA (written)?

☐ English ☐ Spanish ☐ OTHER: _____

Is your child limited English speaking?

☐ NO ☐ YES

Head of Household This is the parent who claims head of household on taxes.

Parent 1 Name: _____ Email: _____

Employed with: _____ Work Phone #: _____

Cell Phone #: _____ ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed

Are you in school? ☐ NO ☐ YES Where? _____

How well do you **speak English**? ☐ Very Well ☐ Well ☐ Not Welll ☐ Not at all

How well do you **read English**? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

How well do you **write English**? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

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Parent 2 Name: _____ Email: _____

Employed with: _____ Work Phone #: _____

Cell Phone #: _____ ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed

Are you in school? ☐ NO ☐ YES Where? _____

How well do you **speak English**? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

How well do you **read English**? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

How well do you **write English**? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

Make sure both sides of this form are fully completed or we will mail it back to be completed.

Thank you for taking the time to answer these questions. You may return these documents to the nearest IMACA preschool, IMACA Admin office at 218 A South Main St, Bishop or mail to IMACA Child Development/Family Services, PO Box 845, Bishop, CA 93515. Fax #: 760-872-5570

Inyo Mono Advocates for Community Action
Child Development/ Family Services
Ph: (760) 873-3001/ Fx: (760) 872-5570

EMPLOYMENT VERIFICATION FORM

Verificación de Empleo

INCOMPLETE FORMS WILL NOT BE ACCEPTED!
¡Formularios incompletos no serán aceptados!

INSTRUCTIONS: <u>One form per parent per employment.</u> Please sign/date the release, then take to your employer to have Section II completed. This form must be completed before determining eligibility for IMACA preschool services.

INSTRUCCIONES: Una de las formas por los padres por el empleo. Por favor, firme y fecha de la liberación, después consultar a su patrón para que la Sección II completado. Este formulario debe ser completado antes de determinar la elegibilidad para servicios IMACA preescolar.

I. PARENT RELEASE OF INFORMATION *(LOS PADRES LA ENTREGA DE INFORMACIÓN)*

I/Yo, _____ authorize you, my employer/supervisor, to provide IMACA with any and all information regarding my employment and pay, including exchanging paystubs or payroll history.

Le autorizo, mi empleador / supervisor, para proporcionar IMACA con la siguiente información con respecto a mi empleo.

_____ _____

Parent Signature/ *Firma de Padre* **Date**/ *Fecha*

II. THIS SECTION TO BE FILLED OUT BY EMPLOYER/ SUPERVISOR ONLY:

II. ESTA SECCIÓN SE PARA SER LLENADO POR EL EMPLEADOR / SUPERVISOR SOLO:

IMACA Head Start/ State Preschool may provide child care services for the parent listed above. In order to document eligibility, we are required to obtain the following (and possibly additional) information from the employer:

This is to certify that: _____ started working: _____
(Employee) (Date Started)

is employed with: _____
(Company Name)

located at: _____
(Address, City, State, Zip Code)

Supervisor's Phone: _____ FAX: _____

Employee is Paid: Hourly $_____/ HR Salaried $_____/ Month Other _____

Payperiods Are: ☐Weekly ☐Every 2 Weeks ☐Twice Monthly ☐Monthly

Employee Receives: ☐Tips ☐Commission ☐Overtime

Work Schedule: ☐ Actual ☐ Approximate ☐ Seasonal ☐ Laid off

**If seasonal or laid off, please provide last day worked: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

Payperiods that are every 2 weeks begin on the same day of the week per pay cycle. Twice monthly pay cycles are 15+ days and are from the 1-15th and 16-30/31st.

I certify that the above information is true and correct. I understand that IMACA has the right to obtain <u>additional information</u> or confirmation of employment, either written or verbal. This information will not be shared with any other entity except IMACA.

_____ _____ _____
Signature of Supervisor Print Supervisor's Name & Title Date

FOR OFFICE USE:

Verified by IMACA: _____ Date: _____

Verified with: _____ Position: _____

Required by California Dept of Education Child Care and Development Regulations Sections 18083 & 18084

Ph: (760) 873-3001
Fx: (760) 872-5570

Inyo Mono Advocates for Community Action
Child Development/ Family Services
Head Start/ State Preschool

FAMILY SIZE DECLARATION

Name of Child you are requesting services for: _____

☐ **Family Size (parents, step-parents and children under 18 only)**

- Adults and children related by blood, marriage, or adoption in the house where the child above is living
- A child not living with their natural or adoptive parents is a family size of ONE.

Please Check Which One Applies:

_____ I am a single parent living with child/children (sign the **Statement of Sole Responsibility** below).

_____ We are a father and mother living together with our child/children.

_____ I am a Foster Parent (provide documentation)

_____ I am an adult other than the parent living with the child/children. Relationship: _____

List names and birth dates of all children under 18 years old living in the home: (Include the child listed above)
(You are **required** to provide IMACA with copies of the birth certificates of all children in the family)

Child 1 Full Name: _____ DOB: _____

Child 2 Full Name: _____ DOB: _____

Child 3 Full Name: _____ DOB: _____

Child 4 Full Name: _____ DOB: _____

Child 5 Full Name: _____ DOB: _____

Child 6 Full Name: _____ DOB: _____

STATEMENT OF SOLE RESPONSIBILITY FOR CHILD

Do not fill this out unless you are the only parent residing in the home with your child(ren) and will show us proof that you are divorced, legally separated and/or unmarried (such as court documents, rental agreements,etc)

I, _____, (state your name) declare under penalty of perjury that I have **sole custody and responsibility** for my child/children listed
My child/children's other parent, _____
is absent from my household for the following reason:
_____

If you have custody, you must provide proof of this and you must also sign the Declaration of Sole Responsibility.

I understand that IMACA Head Start/ State Preschool has the right to verify information presented here for the purpose of determining eligibility for preschool services.

By signing this document, I am declaring under **penalty of perjury** and the laws of the State of California that the above mentioned is true and correct. I understand that if the information above is found to be false or withholding, the enrollment of my child in the IMACA Head Start/ State Preschool is subject to termination.

Parent/Guardian Signature: _____ Date: _____

For office only:
Documents Reviewed: ☐ Birth Certificates ☐ Court Documents ☐ Other: _____
Staff Signature: _____ Date verified: _____

Child Care Data Collection

Privacy Notice and Consent Form

The United States Department of Health and Human Services (HHS) is gathering information about families who receive child care assistance. The information will be reported to the California Department of Education (CDE) and then to HHS. The information will be used for research on the status of child care in the United States and will provide valuable data to persons developing child care programs and policies at the state, local, and national levels.

All the information HHS receives about your family and other families will be summed up and reported to Congress every two years. No person or family will be individually identified in reports made to Congress, the Legislature, other governmental agencies, or the public.

To ensure that children and families receiving child care services are counted only once, **HHS and CDE are requesting the Social Security Number of the head of the family unit receiving child care assistance**. If you do not wish to give your Social Security Number for this purpose, you may still receive child care assistance. Social Security Numbers will help CDE meet HHS reporting requests and state requirements for program statistics. Authority to ask for your Social Security Number for this purpose is stated in Section 98.71(a)(13) of *Title 45* of the *Code of Federal Regulations* , *Education Code* Section 8261.5, and Section 18070 of *Title 5* of the *California Code of Regulations* . Your decision to provide your Social Security Number is voluntary.

I have been informed of the way my Social Security Number will be used.
I understand that if I do not wish to give my number, I can still receive child care assistance.

☐ Yes, my Social Security Number may be used: _____

☐ No, I do not wish to give my Social Security Number for this purpose.

_____ _____

Signature of the **HEAD OF HOUSEHOLD**, *ONLY* Date

_____

Print/Type Name of Head of Household

If desired, you can request a copy of this form. You have the right to access records containing your personal information. For information about this system of records, contact the California Department of Education, Child Development Division, 1430 N Street, Sacramento, CA 95814; telephone (916) 445-1907.

IMACA Income Verification

Inyo Mono Advocates for Community Action, Inc.
Child Development/Family Services
218-A S. Main Street, PO Box 845, Bishop, CA 93515
(760) 873-3001/ Fax: 872-5570

ZERO INCOME DECLARATION FORM
AND
ALTERNATE INCOME VERIFICATION

DO NOT FILL OUT THIS FORM UNLESS YOU HAVE NO DOCUMENTATION OF INCOME OR NO INCOME IN THE LAST 30 DAYS.
(One must be filled out for each person in the household over 18, if applicable)

✓ I have received no income in the last 30 days or I have received income for which I have no documentation.

- If you receive pay stubs, Social Security, CashAid/CalWorks/TANF, Child Support, **you must provide documentation**).
- Use this form if you are paid cash and do not receive paycheck stubs.
- If you have received no income in the last 30 days, write on *Source of Income* : **NO INCOME, NO WORK** and for Date Received, write the last 30 days.

X Source of Income	X Gross Amount	X Date Received
X Source of Income	X Gross Amount	X Date Received
Source of Income	Gross Amount	Date Received

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge. Any deliberate misrepresentation or omission will result in being denied assistance.

X Print Your Name	X Phone Number
X Address	X City, Zip Code
X Client Signature	X Date

People Helping People

IMACA CHILD DEVELOPMENT/ FAMILY SERVICES

HEAD START/ STATE PRESCHOOL

HEALTH PHYSICAL CHECKLIST

Child Development
& Family Services
Head Start/ State Preschool
Administration Office
218-A S. Main Street
P.O. Box 845
Bishop, CA 93515
(760) 873-3001
Fax: (760) 872-5570

Lone Pine Preschool
P.O. Box 497
224 N. Washington
Lone Pine, CA 93545
(760) 876-9988

Bishop-Clarke Preschool
P. O. Box 845
180 E. Clarke St
Bishop, CA 93515
(760) 873-3026

Bishop- Little Promises
P. O. Box 845
Bishop, CA 93515
(760) 872-6832

Mammoth Lakes Preschool
P.O. Box 8106
625 Old Mammoth Road #201
2600 Meridian Blvd
Mammoth Lakes, CA 93546
(760) 924-1653

Lee Vining Mono Lake Preschool
P.O. Box 446
296 Mattly Ave
Lee Vining, CA 93541
(760) 647-6095

Coleville State Preschool
P.O. Box 415
111527 Highway 395
Coleville, CA 96107
(530) 495-2137

Dear Parent(s) of: _____

Welcome to IMACA's Head Start/ State Preschool! We are glad your family could join us. As part of the pre-enrollment process, we require a complete, up-to-date Health Screening, Physical Assessment and Current Immunizations before attending preschool. Please give this packet to your child's doctor to fill out. Make sure the doctor completes **EVERYTHING ON THIS CHECKLIST** before you leave the clinic, or unfortunately, **we will have to send you back to have it all completed.**

- → HGB/ HCT TEST
- → Lead Test
- → Blood Pressure
- → Urine Dipstick/ Urinalysis
- → Height and Weight
- → Vision and Hearing Screen
- → Oral health check (to determine if a dental referral is needed)
- → TB test or waiver
- → Physical Exam/ Assessment
- → **Dr needs to note if the child has a diagnosed allergy/ medical condition/ Rx**

Please return this completed packet (plus additional doctor's notes if applicable) to the preschool or the Admin office at the address to the left. Thank you.

Lista de Chequeo de la Salud Física

Estimados padres de: _____

Bienvenidos a Head Start de IMACA / Preescolar del Estado! Estamos contentos de su familia podrían unirse a nosotros. Como parte del proceso de preinscripción, se requiere una completa y actualizada de la Salud de detección, evaluación física y vacunas al día antes de asistir a preescolar. Por favor, este paquete con el médico de su hijo a llenar. Asegúrese de que el médico completa **TODO EN ESTA LISTA** antes de salir de la clínica, o por desgracia, **tendremos que enviarle de nuevo a tener todo terminado.**

- → Prueba de la sangre HGB/ HCT
- → Prueba de la sangre para el plomo
- → Prueba de presión arterial
- → Prueba de orina
- → Altura Y Peso Y Visión y Oído
- → Una revision de los dientes
- → Prueba de la tuberculosis
- → Prueba de presión arterial
- → **Se requiere una nota del doctor si el niño se le diagnostica alergia o condición médica o está tomando un medicamento recetado.**

Por favor devuelva este paquete completo (así como las notas médicas adicionales si es necesario) que el preescolar o la oficina de administración en la dirección hacia la izquierda. Gracias.

IMACA CHILD DEVELOPMENT/ FAMILY SERVICES- HEAD START/ STATE PRESCHOOL

CHILD HEALTH RECORD- SCREENINGS, PHYSICAL EXAMINATION, TB ASSESSMENT

PART 1. TO BE COMPLETED BY HEALTH CARE PROVIDER PRIOR TO PHYSICAL EXAMINATION/ ASSESSMENT.

Child's Name: _____ Gender: _____ DOB: _____

Head Start Center: **IMACA Head Start/ State Preschool** HmPh 1: _____ HmPh 2: _____

Mailing Address: **PO Box 845, Bishop, CA 93515** Office Ph: **(760) 873-3001** FAX: **(760) 872-5570**

1. RELEVANT INFORMATION:

2. SCREENING TESTS: Starred items (*) are **REQUIRED by Head Start** and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a min. "N" = Normal; "S" = Suspect, or "A" =Atypical/Abnormal.

TEST	DATE	RESULTS
*** Present Age**		Yrs, Mos.
*** Height** (no shoes, nearest 1/8")		
*** Weight** (light clothes, nearest 1/4 lb)		
*** Blood Pressure**		
*** HGB/HCT** (Hemoglobin/Hematocrit)		
*** Lead**		
*** Urinalysis**		
Ova, Parasites		
Other (Indicate)		

TEST	DATE	RESULTS
* **Hearing** (specify type of test)		
Results		
Rescreening		
*** Vision**		
Acuity R/L		
Rescreening		
Strabismus		
Comments		

Part 2. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING PHYSICAL EXAMINATION/ ASSESSMENT

3. PHYSICAL EXAMINATION/ ASSESSMENT	Normal for Age	Abnormal	Not evaluated
A. General Appearance			
B. Posture, Gait			
C. Speech			
D. Head			
E. Skin			
F. Eyes (external and optic)			
G. Ears (external and tympanic)			
H. Nose, Mouth, Pharynx			
I. Teeth			
J. Heart			
K. Lungs			
L. Abdomen (includes Hernia)			
M. Genitalia			
N. Bones, Joints, Muscles			
O. Neurological/ Social			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication skills			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
P. Glands (Lymphatic/ Thyroid)			
Q. Muscular Coordination			
R. OTHER			

S. General Statement of Child's Physical Status:

Any asthma or allergies?

4. COMMENTS (please print clearly)

SCREENING OF TB RISK FACTORS/ TB WAIVER:

☐ Risk Factors Not Present; TB Skin test not required

☐ Risk Factors PRESENT; Mantoux TB test performed:

_____

Date Test Performed

☐ Neg ☐ Pos

RISK FACTORS FOR TB IN CHILDREN:

→ Have clinical evidence of TB

→ Have abnormalities on chest x-ray suggestive of TB

→ Have contact with or family history of confirmed/suspected TB and/or HIV seropositivity

→ Are in foreign-born families with high prevalence countries (Asia, Africa, Central America, South America)

→ Live in and out of home placements

→ Live with someone who has been incarcerated in the last 5 yrs.

→ Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs or nursing home residents.

CARE PROVIDER'S CLINIC STAMP

Dr. Signature and Printed Name

Date