Head Start Family Income Guidelines for 2016

Persons in Family	Federal Poverty Guidelines	Between 101-130% of Federal Poverty Guidelines
1	$11,880	$11,881 - 15,444
2	$16,020	$16,021 - 20,826
3	$20,160	$20,161 - 26,208
4	$24,300	$24,301 - 31,590
5	$28,440	$28,441 - 36,972
6	$32,580	$32,581 - 42,354
7	$36,730	$36,731 - 47,749
8	$40,890	$40,891 - 53,157
For each additional person, add	$4,160	

Hoosier Uplands Head Start/Early Head Start
Self-Identification form for Homeless Children and Families

Participant's Name: _____ DOB: _____

For Head Start purposes and per the McKinney-Vento Assistance Act (section 725 (2), the definition of homelessness is "individuals who lack a fixed, regular, and adequate nighttime residence" and includes children and families living in the following circumstances:

Does the applicant live in any of the following circumstances? Check all that apply

€ In a shelter (family shelter, domestic violence, youth, or temporary housing)

€ In a motel, hotel, or weekly rate housing

€ Doubled up with friends or relatives because the family cannot find or afford housing (not by choice)

€ In an abandoned building, other inadequate accommodations, or a vehicle

€ On the street

€ Temporary foster care placement (statement from DFR required)

€ In a camper or tent

€ In a home without running water and/or electricity

€ In a home without heat

€ Other (explain):_____

Parent Certification:
I/we are currently living in one (or more) of the above situations. I (if I am a pregnant woman) or the child named above should be classified as homeless under Head Start definitions.

Parent/Guardian's Name: _____ Date: _____

Interview Notes (How did the family become homeless, additional information about the current situation, etc.)

Staff Signature: _____ Date: _____

Completed at time of application (if needed) or if income needs re-verified.
Original to Data Entry
2/2016 rm

Information Station

Head Start Income does NOT include the following: capital gains, any assets drawn down as withdrawals from a bank, the sale of property, a house or a car; or tax refunds, gifts, loans, lump-sum inheritances; one time insurance payments or compensation for injury. Also excluded are noncash benefits, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits; food or housing received in lieu of wages; the value of food and fuel produced and consumed on farms; the imputed value of rent from owner-occupied non-farm or farm housing; and such Federal non-cash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance.

Regarding pregnant teenagers: In the case of an unmarried teenage girl, her own income determines her eligibility, regardless of her parents' income. *ACYF HS IM 02 04.* If she has no income, no wage inquiry is required, just have her fill out the zero income statement.

Examples of documents that can be used for verifying income: Income tax forms, check stubs, claim inquiry, bank statements, employer letter, wage inquiry, W-2, an identification form indicating undocumented or zero income, etc.

Social Security Disability Insurance (SSDI)	**Supplemental Security Income (SSI)**
Financed through social security taxes paid by employers and employees	Financed through general revenues from taxes, not based on your prior work history
To be eligible, you must earn sufficient credits from working	To be eligible, you must have limited income and resources
Benefits are payable to: Blind or disabled workers Their children Widow (ers) Adults disabled since childhood	Benefits are payable to: Individuals 65 or older Adults who are disabled or blind Children who are disabled or blind
Award letter will typically say "Social Security Administration" "Retirement, Survivors and Disability Insurance"	Award letter will specifically say "Supplemental Security Income"
NOT automatically eligible for Head Start and requires all income sources to be turned in	Automatically Categorically eligible for Head Start. Income sources are not relevant to eligibility

Divorced parents with joint custody:

Policy Clarification OHS-PC-I-005 states the following: If either of the child's parents are receiving public assistance, the child should be considered income eligible. If this is not the case, the Head Start program should determine if one of the parents is paying any child support to the other parent. If that is the case, the income of the parent receiving the child support should be used for determining income eligibility. If neither parent is providing any child support to the other, the HS program should count half of each parent's income and the sum of these two should be used by the program in determining whether or not the child is low-income. (To determine family size, you would add all the family members in both households and divide in half)

Allergies & Asthma: (this is for Head Start ONLY) In September of 2010, it was decided at a Management meeting that if a child has known allergies and/or asthma, their application will be placed on hold until an Allergy Action Form and/or Asthma Health Plan are received. The Family Case Manager should go ahead and turn the application in to Data Entry, but it will not be placed on the waiting list until completed. The applications that are placed "on hold" can be viewed in ChildPlus by clicking on "Change who appears in this list" on your CP navigator and placing a check mark in the "New" status box.

Incomplete applications: If an application is incomplete, it needs to be sent in to Data Entry to be entered in to ChildPlus and placed on "hold". An application will be placed on hold if any of the following are missing: proof of age, proof of income, a needed asthma health plan or an allergy action plan. Once the app is entered, you can see the apps that you have on hold by showing "New" as a status on Childplus. You can then see exactly what is missing by looking at the enrollment notes on that child. If income is missing, the FCM will interview the family about income sources and remove the income form from the app and keep it until the family turns the income proof in. FCM's should call the family the first week to remind them to bring it in, call them again the second week, then send the family a letter requesting they respond within 2 weeks. When the 2 weeks are up, and you have not heard from the family, send the income form to Data Entry and it will be placed with the incomplete application.

2/2016 rm

Hoosier Uplands Children's Services
500 West Main Street ● Mitchell, IN 47446
812-849-4447 ● 1-800-827-2219 ● 812-849-0627

Hoosier Uplands Head Start/Early Head Start
Release of Information Form

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

I give permission to _____ of the Hoosier Uplands Head Start/Early Head Start
(Head Start/Early Head Start Employee)

program to request and accept the following information regarding the above named child:

_____
(Information Requested)

From: _____
(Agency or Organization)

For the purpose of: _____
(Why Information is Needed)

I have been fully informed and understand the school's request for my consent, as described above. I understand that my consent is voluntary and may be revoked at any time.

This release of information will expire one year from the date below.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Attention Agency supplying information: Please send to the office check-marked below:

___ Admin Office
500 W. Main St.
Mitchell, IN 47446
Phone: 812-849-4447
Fax: 812-849-0627

___Early Head Start
502 W. Warren St.
Mitchell, IN 47446
Phone: 812-849-5446
Fax: 812-849-0627

___Mitchell Head Start
1240 Orchard St.
Mitchell, IN 47446
Phone: 812-849-4448
Fax: 812-849-0627

___Salem Head Start
902 S. Aspen Dr.
Salem, IN 47167
Phone: 812-883-5368
Fax: 812-883-8085

___ Bedford Head Start
710 6th St.
Bedford, IN 47421
Phone: 812-275-0052
Fax: 812-279-1891

___Loogootee Head Start
401 South Oak St.
Loogootee, IN 47553
Phone: 812-295-4700
Fax: 812-295-4700

___Paoli Head Start
414 W. Longest St.
Paoli, IN 47454
Phone: 812-723-3687
Fax: 812-723-4633

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Hoosier Uplands Children's Services Special Diet & Allergy Action Plan

Child's Name _____ DOB _____

☐ Head Start ☐ Early Head Start County: ❑Law. ❑Martin ❑Org. ❑Wash.

Risk Factors (Parent or Physician should complete)

- ❑ This child has the following special diet, food allergy or medical allergy:
  - ❑ Special Diet/Food Intolerance: _____
    - ❍ Medical
  - ❑ Food Allergy: _____
    - ❍ Ingestion ❍ Absorption ❍ Inhalation
  - ❑ Medical Allergy: _____
    - ❍ Insect Sting ❍ Latex ❍ Medication ❍ Other

Asthmatic ❑ No ❑ **YES, *High risk for severe reaction. See: Asthma Action Plan.**

TREATMENT/ PLAN OF ACTION (Must be completed by the child's Physician and include the least restrictive yet safest plan of care)

- ❑ No treatment required.
- ❑ Dietary substitution required as described: _____
  _____
- ❑ Medical treatment required as described: _____
  _____

➢ **Epi Pen required for bus transportation and/or school attendance?** ❑Yes ❑No

SIGNS OF AN ALLERGIC REACTION

Systems: Symptoms:

Skin: Hives, itchy rash, swelling of the face, arms, or legs
Gut: Nausea, abdominal cramps, vomiting, diarrhea
Mouth: Itching & swelling of the lips, tongue, or mouth
Throat:* Itching/tightness in the throat, hoarseness, hacking cough
Lungs:* Shortness of breath, repetitive coughing, wheezing
Heart:* "Thready" pulse, "passing-out", pale, blueness
Other _____

****The severity of symptoms can quickly change. All "starred" symptoms can potentially progress to a life-threatening situation.**

Emergency Care (Medication orders from a licensed provider must be on file.)

- ❑ If ingestion or contact with the allergen is suspected and *NO symptoms* are evident do the following:
  _____
  (plan of action)
- ❑ If ingestion or contact with the allergen is suspected and/or symptoms include:
  _____
  Give _____
  (medication/dose/route)
- ❑ **If symptoms worsen and include:** _____
  Give _____**IMMEDIATELY!**
  (medication/dose/route)

Call

- ❑ 911(ask for advanced life support)
- ❑ The child's parent or guardian.

Parent Signature _____ Date _____

Physician Signature _____ Date _____

Original: Data Entry CC: Health Specialist/Nurse; Cook; Teacher/HV; Bus Driver; Early Ed. Supervisor Rev: DLS 02/06/15

Hoosier Uplands Head Start/Early Head Start
Undocumented and Zero Income Form

Participant Name: _____ DOB: _____

Undocumented Income

Time frame reviewed (Must match time frame in Section C of the eligibility form):

From _____ to _____
(Month, Year) (Month, Year)

I have received income for which no documentation exists for each of the following months:

Year	Month	Amount	**Source of Income** (Child support, employment, tips, etc.)
	Jan		
	Feb		
	March		
	April		
	May		
	June		
	July		
	Aug		
	Sept		
	Oct		
	Nov		
	Dec		

Zero Income:

Time frame reviewed (Must match time frame in Section C of the eligibility form):

From _____ to _____
(Month, Year) (Month, Year)

I have not received income from ANY source for my family during the time frame reviewed to determine eligibility for Head Start.

All families come with different experiences and circumstances. Please explain what sources of funds your family uses to pay for rent and other necessities:

I certify that I have provided to Hoosier Uplands staff complete and accurate information and documentation.

Parent/Guardian Signature: _____ Date: _____

Staff: I certify that I have verified the applicant's eligibility by reviewing all documents provided by the family and have made reasonable efforts to verify the information.

Staff Signature: _____ Date: _____

Completed at time of application (if needed) or if income needs re-verified.
Original to Data Entry
2/2016 rm

Hoosier Uplands Children's Services

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade _____

❒ School E-mail _____ ❒ School Fax (___) _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____

Phone (Cell) _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

Asthma Care Provider _____ ❒ Office Phone (___) _____

❒ Office E-mail _____ ❒ Office Fax (___) _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

	MONITORING	TREATMENT
RED	**RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness	• Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • **Call 911 NOW if:** 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department
YELLOW	**YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to class or normal activity, or** _____ _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ❒ 2 ❒ 3 days, if symptoms remain improved • If symptoms are not gone after ❒ 2 ❒ 3 days, move to the **RED ZONE**
GREEN	**GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	

MEDICATION	HOW MUCH	WHEN
		Before Exercise ❒ Recess ❒ PE/Sports *(not to exceed every 4 hours)*
DAILY CONTROLLER MEDICATION	**HOW MUCH**	**WHEN**

❒ Administer medications as instructed above

❒ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school

❒ Student needs supervision or assistance to use his/her inhaler medication

❒ Student should **NOT** carry his/her inhaler while at school ❒ Have student use spacer with inhaler medication

_____ _____ _____

ASTHMA CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____

PARENT SIGNATURE **DATE**