Community Services Of Northeast Tex

Eligibility Configuration

Selection Criteria 2022-2023

Applies to:

Community Services Of Northeast Tex - Head Start 2022-2023

Automatically assign points based on Income

Foster	200
Homeless	200
Public Assistance	200
0 - 50%	85
51 - 75%	75
76 - 100%	65
101 - 130%	15
131 - 150%	10
151 - 400%	5

Automatically assign points based on Class Age

0 - 35 mo	0
36 - 41 mo	65
42 - 47 mo	75
48 - 53 mo	85
54 - 59 mo	95

Participant is not eligible if less than 36 months old on the school-year cut-off date or at the time of enrollment.

Participant is not eligible if 60 months old or older on the school-year cut-off date.

Other Eligibility Criteria

Attending and/or attended Early Head Start or ECI
- 95 Yes

SNAPS, Medicaid/CHIPS, CCMS, WIC
- 80 Yes

Parental Status
- 95 Guardian
- 90 One Parent/Dad
- 85 One Parent/Mom
- 80 Grandparent raising grandchild
- 75 Two Parent

Disability
- 100 Diagnosed Disabiity with IEP
- 85 Suspected Disability with explanation
- 0 No Diagnosed Disability

Child with sibling enrolled in the program
- 70 Yes

Open case with CPS
- 40 Yes

Over income with a Disability
- 100 Yes

4 Year old with a diability with an IEP
- 20 Yes

3 Year old with a disability with an IEP
- 25 Yes

Homeless, Foster, Kinship or Public Assistance
- 100 Yes

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Community Services Of Northeast Tex

Eligibility Configuration

Selection Criteria 2022-2023

Other Eligibility Criteria

ESL
100 Yes
Active Military
100 Yes
Former Foster Child
100 Yes
Three Year old in Naples/New Boston/Pittsburg
40 Yes
Parent Under the Age of 23
40 Yes
Parent Currently Incarcerated
40 Yes
Parent works for ISD
40 Yes

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Community Services Of Northeast Tex

Eligibility Configuration

EHS Selection Criteria 2022-2023

Applies to:

Community Services Of Northeast Tex - Head Start 2022-2023
Community Services Of Northeast Tex - Head Start 2021-2022
Community Services Of Northeast Tex - Early Head Start 2021-2022
Community Services Of Northeast Tex - Early Head Start 2022-2023

Automatically assign points based on Income

Foster	200
Homeless	200
Public Assistance	200
0 - 50%	85
51 - 75%	75
76 - 100%	65
101 - 130%	15
131 - 150%	10
151 - 400%	5

Automatically assign points based on Class Age

0 - 11 mo	75
12 - 23 mo	85
24 - 36 mo	95

Participant is not eligible if 36 months old or older on the school-year cut-off date.

Other Eligibility Criteria

SNAPS Medicaid/CHIPS, CCMS, WIC
- 80 Yes

Parental Status
- 95 Guardian
- 90 One Parent/Dad
- 85 One Parent/Mom
- 80 Grandparent raising grandchild
- 75 Two Parent

Disability
- 100 Diagnosed Disabiity with IEP/IFSP
- 85 Suspected Disability with explanation
- 0 No Diagnosed Disability

Child with sibling enrolled in the Head Start program
- 70 Yes

Open case with CPS
- 40 Yes

Over income with a Disability
- 100 Yes

Homeless, Foster, or Public Assistance
- 100 Yes

ESL
- 100 Yes

Active Military
- 100 Yes

Former Foster Child
- 100 Yes

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Community Services Of Northeast Tex

Eligibility Configuration

EHS Selection Criteria 2022-2023

Other Eligibility Criteria

Teen Parent

40	Yes

Parent Currently Incarcerated

40	Yes

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HEAD START ENROLLMENT HEALTH HISTORY FORM

Child's Name: ____

Medication

Is your child currently taking any medication? □Yes □No
If yes, what medication and when does the child receive the medication? ______________________________
____

***if your child receives medication at school, medication administration forms need to be completed by doctor**

Medical

Is your child current with well-child exams? □Yes □No Date of Last Exam: _________________________
Is your child being treated by a physician for any of the following conditions?

- □ Anemia/Sickle Cell
- □ Asthma
- □ Diabetes
- □ Seizures
- □ Cardiac Disorders
- □ Vision Problems(glasses/difficulty seeing/headaches)
- □ Hearing Problems (difficulty hearing/tubes/earaches
- □ High Lead Levels

Please specify: ____

Does your child have any of the following allergies that require an EPI-PEN?

- □ Insect Stings/Bites
- □ Medication:___________________________
- □ Poison Ivy/Oak

***If your child has an allergy, an ALLERGY ACTION PLAN will need to be completed by doctor**

Does your child have any of the following problems?

- □ Seasonal Allergies: _____________________
- □ Eczema, hives, other skin problems
- □ Bed wetting
- □ Daytime wetting
- □ Frequent diarrhea
- □ Frequent urination
- □ Frequent constipation
- □ Painful urination
- □ Wears diapers/training pants
- □ Frequent indigestion
- □ Frequent stomachaches
- □ Frequent vomiting
- □ Other: ___________________

Does your child have any of the following conditions?

- □ Bites when angry/frustrated
- □ Bone/joint/muscle disease
- □ Fainting spells
- □ Bone/joint/muscle injury
- □ Hyperactivity
- □ Frequent fevers
- □ Trouble sleeping
- □ Lack of energy

Is your child seeing a medical specialist for ANY reason? □ Yes □ No
If yes, specify: ____

Would you like to set up a meeting with the Health Coordinator to discuss your child's health issues?
□ Yes □ NoDental

Is your child in pain right now because of their teeth? □ Yes □ No

Disability/Mental Health

Does your child have any of the following disabilities?

- □ Autism
- □ Emotional/Behavior
- □ Hearing Deafness
- □ Vision Blindness
- □ Learning Disability
- □ Orthopedic Impairment
- □ IDD
- □ Multiple Disabilities
- □ Speech/Language
- □ Traumatic Brain Injury

Is your child currently seeing a counselor or therapist? ☐ Yes ☐ No
If yes, who? ____
Did your child receive services from Early Childhood Intervention (ECI)? ☐ Yes ☐ No
**** speech/language, physical/occupational therapy***
If yes, which agency?____ **IFSP in place?** ☐ Yes ☐ No

Nutrition

Is your family currently involved with WIC?	☐ Yes ☐ No
Do you have concerns about your child's eating patterns? (picky eater, over/under eating, other)	☐ Yes ☐ No If yes, specify
Does your child take a vitamin or mineral supplement that contains iron and/or fluoride?	☐ Yes ☐ No If yes, specify
Were the supplements prescribed?	☐ Yes ☐ No
Are there foods not eaten for medical, religious, cultural, or personal reasons?	☐ Yes ☐ No If yes, specify
Is your child on a special diet?	☐ Yes ☐ No If yes, specify
Has your child's appetite changed in the past month?	☐ Yes ☐ No If yes, specify
Does your child have trouble chewing or swallowing?	☐ Yes ☐ No If yes, specify
Do you have any concerns about what your child eats or your child's weight?	☐ Yes ☐ No Please list concerns:_________________________________ ____
Does your child have a food allergy documented by a physician?	☐ Yes ☐ No
Does your child need nutritional treatment?	☐ Yes ☐ No List the treatment you feel your child needs ___________ ____
Is your child receiving nutritional treatment?	☐ Yes ☐ No List the treatment your child is receiving ______________ ____

Special Concerns

List any additional concerns

____

____

____ ____________________________

Parent/Guardian Signature **Date**

____ ____________________________

Staff Signature **Date**

I verify that I have reviewed this health history form and have taken any needed actions regarding this child.

____ ____________________________

Teacher Signature **Date**

Revised: 1/20/2022

Head Start
"Building partnerships, changing lives"

EARLY HEAD START ENROLLMENT HEALTH HISTORY FORM

Child's Name: ___________________________________ Date of Birth: ________________________

Birth

Delivery Method: ◻Vaginal ◻C-Section
Birth Weight: _____________________ Length: _______________________
Gestation Age: _________weeks ◻Unknown
Birth Facility: ____

Describe any complications associated with this delivery (Pre-term labor, fetal distress, etc.)
____
____

Did the baby have any problems at birth? ____
Describe any observable defects.____
Did the mother have any health problems during this pregnancy (High Blood Pressure, Diabetes, etc.)
____
____

Medication

Is your child currently taking any medication? ◻Yes ◻No
If yes, what medication and when does the child receive the medication? ____________________________
____

if your child receives medication at school, medication administration forms need to be completed by doctor

Medical

Is your child current with well-child exams? ◻Yes ◻No Date of Last Exam: ________________________
Is your child being treated by a physician for any of the following conditions?

- ☐ Anemia/Sickle Cell
- ☐ Asthma
- ☐ Diabetes
- ☐ Seizures
- ☐ Cardiac Disorders
- ☐ Vision Problems(glasses/difficulty seeing/headaches)
- ☐ Hearing Problems (difficulty hearing/tubes/earaches
- ☐ High Lead Levels

Please specify: ____
____

Does your child have any of the following allergies?

- ☐ Insect Stings/Bites
- ☐ Medication:___________________________
- ☐ Poison Ivy/Oak

Does your child require an EPI-PEN? ☐ Yes ☐ No

If your child has an allergy, an ALLERGY ACTION PLAN will need to be completed by doctor

Does your child use diapers or pull ups? ☐ Diapers ☐ Pull Ups ☐ Potty Trained

Preferred Brand: ______________________
Size:________________________________

Does your child have any of the following conditions?

- ☐ Bone/joint/muscle disease
- ☐ Fainting spells
- ☐ Bone/joint/muscle injury
- ☐ Hyperactivity
- ☐ Frequent fevers
- ☐ Trouble sleeping
- ☐ Lack of energy

Is your child seeing a medical specialist for ANY reason? ☐ Yes ☐ No
If yes, specify: ____

Would you like to set up a meeting with the Health Coordinator to discuss your child's health issues?
☐ Yes ☐ No

Dental

Is your child in pain right now because of their teeth? ☐ Yes ☐ No

Nutrition

Is your family currently involved with WIC?	☐ Yes ☐ No Where? ______________________________
What does your child drink from?	☐ Regular Cup ☐ Sippy Cup ☐ Bottle
What milk does your child drink?	☐ Breast ☐ Whole Milk ☐ 2% ☐ 1% ☐ Lactose Free ☐ Other: _____________________
Is your child documented as lactose intolerant per physician?	☐ Yes ☐ No
Does your child take a vitamin or mineral supplement that contains iron and/or fluoride?	☐ Yes ☐ No If yes, specify
Were the supplements prescribed?	☐ Yes ☐ No
Are there foods not eaten for medical, religious, cultural, or personal reasons?	☐ Yes ☐ No If yes, specify
Is your child on a special diet?	☐ Yes ☐ No If yes, specify
Has your child's appetite changed in the past month?	☐ Yes ☐ No If yes, specify
Does your child have trouble chewing or swallowing?	☐ Yes ☐ No
Do you have any concerns about what your child eats or your child's weight?	☐ Yes ☐ No Please list concerns:_______________________________ ____
Does your child have a food allergy documented by a physician?	☐ Yes ☐ No If yes, specify
Does your child need nutritional treatment?	☐ Yes ☐ No List the treatment you feel your child needs ___________ ____
Is your child receiving nutritional treatment?	☐ Yes ☐ No List the treatment your child is receiving ______________ ____

Disability/Mental Health

Does your child have any of the following disabilities?

- ☐ Autism
- ☐ Emotional/Behavior
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ Learning Disability
- ☐ Orthopedic Impairment
- ☐ IDD
- ☐ Multiple Disabilities
- ☐ Speech/Language
- ☐ Traumatic Brain Injury

Did your child receive services from Early Childhood Intervention (ECI)? ☐ Yes ☐ No

**** speech/language, physical/occupational therapy***

If yes, which agency?____ **IFSP in place?** ☐ Yes ☐ No

Does your child have any sleeping problems? ☐ Yes ☐ No

What time does your child go to bed? ____________________ **Wake up?**________________

Does your child take a nap? ☐ Yes ☐ No

Does your child sleep through the night? ☐ Yes ☐ No

Does your child have frequent nightmares? ☐ Yes ☐ No

Has your child been in daycare or go to a babysitter? ☐ Yes ☐ No

Does your child play well with others? ☐ Yes ☐ No

Special Concerns

List any additional concerns

____

____

____ ________________________________

Parent/Guardian Signature **Date**

____ ________________________________

Staff Signature **Date**

I verify that I have reviewed this health history form and have taken any needed actions regarding this child.

____ ________________________________

Teacher Signature **Date**

Head Start

"Building a better tomorrow"

Returning Student Update Form

Child's Name: ______________________________________

Current Address: ____

____

Parent/Guardian Contact Number: ____

My child may be released to the following people:

Name: _______________________________________ **Relationship:** _________________________

Phone Number: _______________________________

Name: _______________________________________ **Relationship:** _________________________

Phone Number: _______________________________

Name: _______________________________________ **Relationship:** _________________________

Phone Number: _______________________________

Has your child had any major illnesses or injuries in the past twelve months?

____

____

<u>Allergy:</u>
Does your child have any new allergies diagnosed by a doctor in the past year: □ Yes □ No
If yes, what allergy: ____

Does this allergy require an Epi Pen? □Yes □No

Parent Signature: ____ **Date:** _____________

Staff Signature: ____ **Date:** _____________

Revised: 1/20/2022

Head Start

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Child Health Form
Medical / Dental Home

Child's Name: ___________________________

Insurance Type:
_______ CHIPS
_______ Medicaid
_______ Private: __________________________________
_______ Other: ___________________________________
_______ No Coverage

Policy Number: ________________________________
Dental Included: _______ Yes ________No

Current Medical Provider: __________________________________
Phone: __________________________________
________ None at this time

Current Dental Provider: __________________________________
Phone: __________________________________
_________None at this time

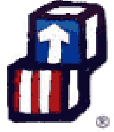
Hospital to use in case of an emergency:
____

	Chronic Conditions	Diagnoses Date	Plan Completed (Office Use Only)
	Autism		IEP – Yes/No
	ADHD		Physical Form – Yes/No
	Hearing Problems		Audiologist Report – Yes/No
	Vision Problems		Optometrist Report – Yes/No
	Seizures		SAP – Yes/No
	Diabetes		DAP – Yes/No
	High Lead Levels		Treatment Plan – Yes/No

	Life Threatening Allergies (EPI pen)		Allergy AP – Yes/No
	Asthma		AAP – Yes/No

Head Start

"Building partnerships, changing lives"



Receipt of Handbook

I have received a copy of the Head Start Operating Manual which includes: Parent Handbook, USDA Parent Resource Guide, Volunteer Handbook, and Resource Directory for 2022-2023. You are encouraged to read and understand this manual as there will be information that you may need during the school year. The handbook includes:

Discipline and guidance	*Procedures for release of children*
Suspension and expulsion	*Illness and exclusion criteria*
Emergency plans	*Procedures for dispensing medicines*
Procedures for conducting health checks	*Immunization requirements*
Safe sleep	*Meals and food service practices*
Procedures for parents to discuss concerns with the director	*Procedures to visit the center without securing prior approval*
Procedures for parents to participate in operation activities.	*Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website.*
Class Schedules	

Available on the website is the: Resource Directory, Campus Menus, Volunteer Application, Immunization Chart, USDA Parent Letter, WIC information, Building for the Future flyer, and School Calendars.

________________ *I will access the parent handbook at www.csntexas.org.*

_______________ *I would like a paper copy of the handbook.*

____ ______________________

Signature of parent *Date*

____ ______________________

Staff Signature (for receipt of their Handbook) *Date*

Please sign and date this page, remove it, and return it to your Family Service Worker.

Updated: 1/19/2022

Students Name: ____

Updated: 1/19/2022