Youth & Family Services
Home-Based Early Head Start®

Prenatal Enrollment Application

We are pleased that you are applying for our program! Youth & Family Services Head Start provides a comprehensive program that includes early childhood education, health, nutrition, family partnerships, and advocacy services for enrolled families.

YFS Head Start recognizes parents as the primary educators of their children. Through your involvement in the program, you will have many opportunities to learn and grow with your child. We look forward to sharing the YFS Head Start experience with you and your family!

To complete the enrollment process, YFS Head Start will need the following information:

- ❑ **Completed Application** (mandatory for enrollment)
- ❑ **Family's Proof of Income** (mandatory for enrollment)

1920 N. Plaza Blvd. • PO Box 2813 • Rapid City, SD 57709

Fax: (605) 342-0693 • **Phone:** (605) 342-4195 • **Toll Free:** (800) 568-0202

EXPECTANT MOTHER'S INFORMATION

First	Middle	Last	Date of birth
Street		City	
State	Zip	County	

Mailing address (if different than living address)

Cell phone ( )	Home phone ( )	Work phone ( )
Message phone ( )	Email	
Primary language spoken in your home:	Secondary language spoken in your home (if any):	

Race & Ethnicity (please check all that apply): □ American Indian/Alaskan Native □ Black or African American □ White
□ Native Hawaiian/Pacific Islander □ Multi-racial or bi-racial □ Asian □ Other, please specify: _____

Are you Hispanic/Latino? □ Yes □ No

Employment
Are you employed? □ Yes □ No **If yes, where?** _____ □ Full-time □ Part-time □ Seasonal
□ Retired □ Disabled Are you currently attending school or training? If yes, where? _____
Are you an active member of the U.S Military? □ Yes □ No **Are you a veteran of the U.S Military?** □ Yes □ No

Education
Highest level completed: □ Less than high school graduate □ High school graduate or GED
□ Associate's degree, vocational school, or some college □ Advanced degree or bachelor's degree

SECONDARY PARENT/GUARDIAN WHO RESIDES IN HOME (If applicable)

First	Middle	Last
Date of birth	Relationship to child	
Cell Phone ( )	Home Phone ( )	Work Phone ( )
Message Phone ( )	Email	

Employment
Are you employed? □ Yes □ No **If yes, where?** _____ □ Full time □ Part time □ Seasonal
□ Retired □ Disabled Are you currently attending school or training? If yes, where? _____
Are you an active member of the U.S Military? □ Yes □ No **Are you a veteran of the U.S Military?** □ Yes □ No

Education
Highest level completed: □ Less than high school graduate □ High school graduate or GED
□ Associate's degree, vocational school, or some college □ Advanced degree or bachelor's degree

Is this person covered by health insurance? □ Yes □ No **If no, is health insurance offered/available?** □ Yes □ No

Please list all other persons living within your home who are NOT included above. If this person is an emergency contact, please add to the Emergency Contact section.

Name	Relationship	Date of birth

REQUIRED HEATH AND NUTRITION

Within 30 days of enrollment, our program must determine whether each enrolled pregnant woman has an ongoing source of continuous, accessible health care.

Health/Dental Care Information

□ Indian Health Services (IHS) □ Private health insurance □ No health insurance □ Medicaid/CHIP/Title 19
□ IHS dental services □ Private dental insurance □ No dental insurance □ Tricare

Your doctor:	**Name of clinic:**	**Date of first prenatal visit:**	**Due date of child:**
Your dentist:	**Name of clinic:**	**Date of last visit:**	

Will the father figure be involved with the pregnancy and after baby's birth? □ Yes □ No

Do you have concerns about this pregnancy? □ Yes □ No
If yes, please specify: _____

Are these concerns/needs currently met or addressed with your medical provider? □ Yes □ No

_____

_____

Is this a high-risk pregnancy? □ Yes □ No
If yes, please explain: _____

Are you on a special diet prescribed by a health care professional or do you restrict foods because of religious preference? □ Yes □ No
If yes, please describe:_____

Are you a diabetic? □ Yes □ No

PREVIOUS ENROLLMENT INFORMATION:

Has anyone in your family been previously enrolled in Early Head Start or Head Start? □ Yes □ No
If yes, please mark all that apply:

	Child	Other Family Member
Early Head Start		
Head Start		
YFS Child Development Center		
Non-YFS program		

How did you hear about our program?

EMERGENCY CONTACTS

Persons listed below must be at least 13 years of age. Persons listed will be utilized as alternate points of contact for emergencies. Please try to list at least one.

Full Name		Relationship to self	
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	
Full Name		Relationship to self	
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	
Full Name		Relationship to self	
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	

ADDITIONAL INFORMATION

What is your current living situation? □ Own □ Rent □ Motel □ Shelter/mission □ Living with relatives

□ Other _____

How long have you lived at this address: _____

Does your family have access to a reliable means of transportation? □ Yes □ No
If yes: □ Private vehicle □ Friend's or relative's vehicle □ Public transportation □ Other _____

How many vehicles does your household have? _____

Are there any concerns or family situations that we should be aware of to help meet your needs? □ Yes □ No
If yes, please describe:

Is there a protection/restraining order in effect? □ Yes □ No *If yes, please provide a copy with your application.*

Does your family receive any of the following types of services or financial assistance?
Please check all that apply:

□ SSI (Supplemental Security Income) □ TANF *Please list caseworker*:_____
□ SNAP/food stamps □ Child care assistance □ WIC □ No services

Youth & Family Services Consent Form

Your Name: _____

Please INITIAL each of the following items:

	YES	NO	
1.			I authorize Youth & Family Services staff to release my name, telephone number, and/or address to other parents for the purpose of communicating with me about specific program activities.
2.			I authorize Youth & Family Services to include information about me and/or my family in the YFS program newsletter. I understand that the newsletter is distributed to program staff and other enrolled families. This information may include, but is not limited to: me and/or my family name, me and/or my family photographs, me and/or my family achievements or successes, birthdays, and participation in program activities.
3.			I authorize Youth & Family Services to transport me for required Early Head Start activities when available. Youth & Family Services requires that seat belts be used in all vehicles.
4.			I authorize Youth & Family Services to take photographs/videos of me and/or my family for program use.
5.			I authorize Youth & Family Services to photograph/video me and/or my family. I understand the photographs and footage may be used for the purpose of publicity, illustration, commercial art, and in the advertising of a product or service directly related to Youth & Family Services.
6.			I authorize Youth & Family Services to transfer my child/family records within Youth & Family Services programs in the event that my child/family transfers/participates from one program option to another program option.

Non-Discriminatory Clause: It is the policy of Youth & Family Services to not discriminate on the basis of race, sex, age, color, national origin, or disabilities in the provision of services and employment.

Confidentiality Statement: Information shared with Youth & Family Services will be kept strictly confidential unless its release is authorized in writing.

These forms will be maintained in locked files.

DISCLAIMERS AND SIGNATURE

I hereby release Youth & Family Services from all legal responsibilities or liability that may arise from acts I have authorized above. I would like a copy of this consent form: ❑ Yes ❑ No

Signature _____ Date _____

I hereby give my consent for Youth& Family Services to provide emergency medical treatment and transportation in the event of a medical emergency. I am aware and understand that I will be responsible for the payment of any medical treatment necessary.

Signature _____ Date _____