

MANCHESTER EARLY CHILDHOOD PROGRAMS

406 WEST PLUM STREET
GEORGETOWN, OH 45121

CALL: (937) 378-6041 or (800) 553-7393, Ext.244, 245 or 247
FAX: (937) 378-3039 E-Mail: abhs_app@yahoo.com

ADAMS-BROWN HEAD START

Options:

-Tuesday thru Friday

-Center Base

1/2 Day classes:

8:00-11:30 or

12:30-4:00

1 at Peebles

Full Day classes:

8:00-2:00

3 at Tiffin

Criteria:

-3 & 4 Years of Age

-Income Guidelines for

Eligibility

ONCE ACCEPTED:

*Must have a completed physical and dental exam (assistance provided, if needed)

Services Offered:

- Nutritious Lunch & Snack

-Special Needs & Non Special Needs

-Parent Involvement

-Social Services

-Health Services

-Vision and Hearing Tests

-Kindergarten Readiness

-Play Indoors & Outdoors in a Safe setting

-No Charge for Services

"class times are subject to change"

WITH APPLICATION:

Mail, E-Mail or Fax copies of:

*Proof of Income

*Birth Certificate

*Shot Record

*Medical / Insurance Card

*Social Security Card

(If applicable)

*Custody Papers

*Foster Care Statement

*Individual Education Plan (IEP)

All centers are licensed by the Ohio Department of Job & Family Services.

-Center Base Option

Each classroom has a teacher, bus driver/teachers aide and bus monitor/teacher's aide. A cook/cook aide or nutrition/classroom aide is at each site to assist in the preparation and delivery of all meal services. Activities in each learning center are individually planned so that children will have the best opportunity for learning while they are in the classroom. The center based option operates on the premise that children learn through play with support and guidance from trained teachers.

-Home Base Option

Families receive the same services as those participating in center-based programs, through a home-based setting. Home Visitors support families through home visits and group socialization experiences. Home visits are planned to support the parents in their roles as primary caregiver and to focus on each child's development need. The home visitor and the family form a strong working relationship and a trusting partnership.

-Bus transportation is provided to as many children as possible for Center Base and Home Base Clusters.

All Head Start Classrooms Run From September Through May.

MANCHESTER SCHOOL DISTRICT PRESCHOOL & DISABILITIES CLASSROOMS

Located at Manchester Elementary – (800) 553-7393 Ext. 244 or 245

MANCHESTER PRESCHOOL

-1 Classroom -1/2 Day program

-Income Guidelines for Eligibility

-Monday thru Thursday

7:45-11:00 or 11:45-3:00

-4 year olds

-Snacks Provided

-Serves non special needs

-Transportation Provided

DISABILITIES PRESCHOOL

-1 Classroom

-Serves Special needs

-Lunch and Snacks Provided

-Monday thru Thursday 8:30 – 1:50

-No Income Guidelines

-Age 3, 4 & 5 year olds

-Transportation Provided

937-549-4777

EARLY HEAD START

10140 St. Rt. 125, Decatur, Ohio 45115 (937) 373-0106 or (877) 582-2140

-No Charge for the Full Year Program

-Income guidelines for eligibility

-Serves infants and toddlers up to age 3 years old

-Offers parent involvement, education, health and social services

-Weekly home visits

-Play groups offered 2 times per month

-Serves special needs and non-special needs children

-Encourages prenatal care in pregnant women, call for a application

HELP ME GROW

3964 Wheat Ridge Road, West Union, OH 45693 (937) 544-2038

Home Visiting Program

-200% Poverty Guidelines

-Ongoing Home Visits

-Information on Child Development & Parenting

-Activities to Stimulate your Child's Development

-Playgroups

-No Cost Developmental Screenings

-Connections to other Community Services

Early Intervention Program

-No Income Guidelines

-No Cost Screening & Evaluation

-Service coordination to find specific Programs (aka Therapies)

-Services to Meet your Child's Needs

-Connections to Other Community Resources

(OVER)

PRESENT LEVELS OF CHILD'S PERFORMANCE

Child's Name _____ Completed by _____ Date: _____
(Date of Birth)

Please describe applicant child's present skills in the following areas by checking the box in each section that most closely describes applicant child's best current performance.

Is applicant child currently enrolled in EHS (Early Head Start)?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Is applicant child currently enrolled in HMG (Help Me Grow)?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Is applicant child currently on an IEP (Individual Education Plan)?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Has applicant child been referred for multi-factor (testing)?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
If yes: Where? _____	By Whom? _____

EATING

- Needs to be fed
- Partially self-feeds
- Eats and drinks independently

DRESSING

- Needs to be dressed
- Removes small articles of clothing
- Dresses self except shoes

HEALTH CONDITION

- Requires on-going treatment
- Will require assistance while at school
- Staff will need training

ATTENTION

- Needs constant attention/supervision
- Occupies self with toys for 10 or more minutes
- Attends to small-group activity for 10 or more minutes

RECEPTIVE LANGUAGE

- Does not appear to understand words
- Shows understanding of several words
- Can follow simple commands and directions

EXPRESSIVE LANGUAGE

- Uses gestures and/or sounds
- Says at least 10 words you can understand
- Says two or three words together
- Uses sentences

HEARING

- Does not respond regularly to sounds
- Responds to simple directions given when back is turned
- Looks at or reacts correctly to sources of sounds
(looks at phone when it rings, turns when name is called)

COGNITIVE

- Looks for toy or person who is out of sight
- Sorts toys or objects by at least one feature
- Counts to four and names two or three colors

FINE MOTOR

- will need help to pick up food or small toys
- independently picks up small toys & transfers objects from hand to hand

PLAY

- Needs stimulation to be provided by someone
- Can hold and manipulates toys
- Uses some toys and object appropriately
- Uses imagination to play (pretends)

GROSS MOTOR

- Needs to be carried or moved by someone
- Crawls to move
- Walks independently

VISION

- Does not show recognition of people or objects
- Points to and names things and people in picture
- Recognizes familiar people and toys,
locates familiar objects in the house

SOCIAL

- Takes turns in simple games
- Shows little response to other people
- Sometimes shares toys and cooperates in play

FAMILY

- Anyone in the household with diagnosed disabilities
Specify Whom: _____

CONCERNS: _____

Please return this form with Application



Recruitment Application

Adams-Brown Head Start
Ages Three & Four
Fax: 937-378-3039

406 West Plum St., Georgetown, Ohio 45121, Attn: Trish C.
1-937-378-6041 or 1-800-553-7393
E-Mail: abhs_app@yahoo.com

(Child) Applicant Information:						
First Name		Last Name		Date of Birth:	County:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address where applicant / child resides: Street/P.O Box:				Pick-up / Drop off Directions:		
Town/City:	State:	Zip Code:	Birth Place / Hospital Name:	How Many People live in the Home? Do you have Transportation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Household Composition: List the primary caregivers.						
Applicant lives with: (Check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Homeless Family		<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Living Together <input type="checkbox"/> Single <input type="checkbox"/> Widowed Language(s) spoken in the child's home? Primary: _____ Secondary: _____ Family income before taxes (yearly total) \$ _____ Are you receiving child care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your family receive any of the following services or financial assistance? (Please indicate all that apply.) <input type="checkbox"/> Public Assistance-OWF <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Financial Aid/Student Loans <input type="checkbox"/> Foster Care/Adoption Subsidy <input type="checkbox"/> Public Housing Assistance <input type="checkbox"/> WIC <input type="checkbox"/> Child support/alimony <input type="checkbox"/> Social Security <input type="checkbox"/> Medical Card <input type="checkbox"/> Energy Assistance <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other _____		
Mother / Guardian:						
First Name		Last Name		Date of Birth:	Social Security Number	
Contact Information: e-mail: _____ Home: (____) _____ Cell phone: (____) _____ Message: (____) _____				Are you attending school / job training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____		
Are you paid / employed: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> 2x Month <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Laid Off Employer & Number: _____				Highest level of education completed: <input type="checkbox"/> Less than 12th Grade <input type="checkbox"/> High School Grad. <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> 2 yr Degree <input type="checkbox"/> 4 yr Degree Other _____		
Father / Guardian:						
First Name		Last Name		Date of Birth:	Social Security Number	
Contact Information: e-mail: _____ Home: (____) _____ Cell phone: (____) _____ Message: (____) _____				Are you attending school / job training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____		
Are you paid / employed: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> 2x Month <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Laid Off Employer & Number: _____				Highest level of education completed: <input type="checkbox"/> Less than 12th Grade <input type="checkbox"/> High School Grad. <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> 2 yr Degree <input type="checkbox"/> 4 yr Degree Other _____		
Other Household Member Information: Please list all <i>other</i> persons living within the home not listed above.						
First Name	Last Name	Date of Birth	Gender	Former Head Start Child?	Child Still Living at Home?	Relationship to Applicant Child
Other Early Education						
Any other children in household currently enrolled in EHS (Early Head Start)? <input type="checkbox"/> Yes or <input type="checkbox"/> No						
Specify who referred your family to the Head Start program?						

I FULLY UNDERSTAND THAT THE ABOVE STATEMENTS MADE BY ME ARE CORRECT TO THE BEST OF MY KNOWLEDGE. INCORRECT STATEMENTS COULD LEAD TO THE DISMISSAL OF MY CHILD FROM THE PROGRAM.

SIGNATURE OF PARENT / GUARDIAN _____ DATE _____

OPTIONAL:

Race <input type="checkbox"/> Biracial or Multiracial	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> White	<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
<input type="checkbox"/> Other _____		

Parental Agreement for Health Services

Child's Name _____ Date of Birth: _____

This is an agreement stating you will get a physical and dental exam as required by State and Federal rules for your child to be ENROLLED in Head Start. **FIRST** we need to receive the application, proof of income, shot record, birth certificate, copy of medical card or insurance card (if you have one) and custody papers (if this applies). We will mail the physical and dental forms once your child has been accepted.

PHYSICAL EXAM

***Rule 5101:2-12-58 of the Ohio Day Care Licensing, and Head Start Performance Standards, states that each child attending Head Start must have documentation of a current physical examination (within past 12 months) and an up-to-date immunization record (or in process) within 30 days of enrollment. The physical examination should be recorded on a Head Start Physical form and must include the following: Hearing, Vision, Speech, Lead screenings, Hematocrit or Hemoglobin, Blood Pressure, Height and Weight.

I understand that I must provide this documentation within 30 days of enrollment for my child to remain in the center or if in Home Base, to attend the monthly center socializations, per state licensing requirements. I agree to schedule and take my child for the physical examination and to follow-up on any problems detected. Follow-up treatment must begin within 30 days of the initial exam.

**I give my child's physician _____ at _____ permission to release medical information to Adams Brown Head Start.

Parent/Guardian Signature

Date

DENTAL EXAM

***Head Start Performance Standards, states that each child attending Head Start must receive a complete dental exam, along with any follow-up treatment needed. The exam and follow-up should be recorded on a Head Start Dental form. I agree to schedule an appointment and take my child to the dentist for a complete dental exam with-in 90 days of enrollment in the Head Start program. If needed, I agree to take my child back to the dentist for treatment until all needed treatment is completed.

**I give my child's dentist _____ at _____ permission to release dental information to Adams Brown Head Start.

Parent/Guardian Signature

Date

WIC RELEASE for ImpactSIIS

***Ohio Day Care Licensing requires documentation be provided to Head Start of an up-to-date immunization record within 30 days of child's enrollment. In signing this release the Adams Brown WIC Program may obtain this record through ImpactSIIS, the secure Ohio immunization health information system.

***I give my permission to the Adams Brown County WIC Program to release the following information to the Adams Brown Head Start Program: A copy of my child's immunization records which the Adams Brown County WIC Program will obtain from Ohio ImpactSIIS.

Parent/Guardian Signature

Date