



SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START PROGRAM

P.O. Box 836, Rosebud, SD 57570
Phone (605) 747-2391 * Fax (605) 747-2590

WELCOME PARENTS TO THE SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START PROGRAM

2023-2024 School Year

The Sicangu Lakota Oyate Head Start/Early Head Start Program provides a comprehensive program that includes Early childhood, Education, Nutrition, Family Partnerships, & Disability advocacy services for enrolled families.

The SLO Head Start/Early Head Start Program recognizes parents as the primary educator of their child. With your family engagement in the program, you will have many opportunities to learn and grow with your child. We look forward to sharing the Head Start/Early Head Start experience with you and your family.

To complete the enrollment process you will need to
Provide the following information:

- Complete enrollment packet
- Dental Screening
- Physical Exam
- Lead Screening
- Child's Birth Certificate
- Degree of Indian blood or Pending letter
- Recent Income Verification
- Medicaid Card
- IEP or IFSP (if available)
- Current Immunization

For further information regarding SLO Head Start/Early Head Start Enrollment
Please contact one of the following Family Advocates at:

April Martinez – Rosebud Classrooms, ext. 223
Feri Veloz – Antelope, Stephan Fallis, Neola Spotted Tail, ext. 212
Caitlin Whiting – Mercy Poorman, Wakanyeja, Yellow Hawk, ext. 218
Lucy Fire Cloud – Kate Omaha Boy, Owl Bonnet, Arrow, ext. 201
Chey D. Marshall – Billy Mills, Woksape, Long Warrior/Dunham, ext. 201
Valene Hawk – Sungh'Pala, Tusweca, Wanbli, Kimimila, Sunka Wakan, ext. 228
Liza Castro – Keya, Sungmanitu Tanka, Pahin, Sungmanitu Cika, Mato, Tatanka, ext. 227
Victoria Burnette – Lame Deer Classroom, also ERSEA Assistant, ext. 209
Debb M. LeRoy – ERSEA Manager, ext. 215

ENROLLMENT CHECKLIST

Classroom: _____

CHILD INFORMATION				
First Name	MI	Last Name	Date of Birth	Age
Parent/Legal guardian First Name and Last Name			Primary Home Phone	
Mailing/Physical Address			Primary Cell Phone	
Primary Work Phone			Date of Application	
Directions to Home				

ERSEA AREA ONLY					
HEALTH		DISABILITIES		FAMILY SERVICES	
Physical		IEP/IFSP		Enrollment Checklist	
Dental		EDUCATION:		Parent Consent	
		JOM		Family Assessment Rel.	
				Video Surveillance Policy	
				Family Information	

DOCUMENTS NEEDED					
Birth Certificate		Medicaid		Signed Income Form	
Tribal Abstract		Immunization		Income Verification	
Guardianship/Custody				No Income Form	

ELIGIBILITY					
Criteria Points		Eligibility %		Foster Child	
		SNAP		Homeless	

FAMILY INFORMATION

Applicant	First Name	M.I.	Last Name	Date of Birth
Child's Name:	[] Female [] Male			
Race	Ethnicity Hispanic	Primary Language		
[] Native American [] White [] Other	[] Yes [] No	[] English [] Spanish [] Other:		
Medicaid	Dental Insurance	Primary Health Care Provider	Private Health Insurance	
[] Yes [] No	[] Yes [] No		[] Yes [] No	
Diagnosed Disability	IEP	IFSP	Food Allergy	Explain food allergy
[] Yes [] No Explain:	[] Yes [] No	[] Yes [] No	[] Yes [] No	

Primary Adult	First Name	M.I.	Last Name	Date of Birth
	[] Female [] Male			
Race	Ethnicity Hispanic	English Proficiency		Lakota Language Spoken
[] Native American [] White [] Other	[] Yes [] No	[] None [] Moderate [] Little [] Proficient		[] None [] Basic [] Fluent
Highest Grade Completed		Employment Status		Child's Relationship
[] Associate's [] Bachelor's [] Master's [] Some College [] GED	[] Grade 10 [] Grade 11 [] HS Diploma [] < Grade 9 [] Did not finish	[] Full-time [] Part-time [] Seasonal [] Unemployed [] Retired or Disabled [] In school		[] Biological / Adopted / Step [] Grandchild [] Other Relative [] Foster [] Other
Custody	Check all that apply		Email Address	
[] Yes [] No	[] Lives with Family [] Provides financial Support			

Secondary Adult	First Name	M.I.	Last Name	Date of Birth
	[] Female [] Male			
Race	Ethnicity Hispanic	English Proficiency		Lakota Language Spoken
[] Native American [] White [] Other	[] Yes [] No	[] None [] Moderate [] Little [] Proficient		[] None [] Basic [] Fluent
Highest Grade Completed		Employment Status		Child's Relationship
[] Associate's [] Bachelor's [] Master's [] Some College [] GED	[] Grade 10 [] Grade 11 [] HS Diploma [] < Grade 9 [] Did not finish	[] Full-time [] Part-time [] Seasonal [] Unemployed [] Retired or Disabled [] In school		[] Biological / Adopted / Step [] Grandchild [] Other Relative [] Foster [] Other
Custody	Check all that apply		Email Address	
[] Yes [] No	[] Lives with Family [] Provides financial Support			

FAMILY CONTACT INFORMATION

Physical Address		City	State	Zip Code	County			
Mailing Address (if different)		City	State	Zip Code	County			
Phone Numbers	Opt in for Text Messages		Primary	Secondary	Notes:			
Cell #	[] Yes [] No		[]	[]	Message #			
Cell #	[] Yes [] No		[]	[]	Message #			
Home #			[]	[]				
Work #			[]	[]	Work Place:			
Parental Status	Homeless Family	Active-Duty Military	Veteran	WIC	TANF	SNAP	SSI	Referred by DSS
[] 1 parent [] 2 parent	[] Yes [] No	[] Yes [] No	[] Yes [] No	[] Yes [] No	[] Yes [] No	[] Yes [] No	[] Yes [] No	[] Yes [] No

OTHER HOUSEHOLD MEMBERS

Adult/Child	First	M.I.	Last	DOB	Gender
					[] Female [] Male
					[] Female [] Male
					[] Female [] Male
					[] Female [] Male
					[] Female [] Male
					[] Female [] Male
					[] Female [] Male
					[] Female [] Male

How did you hear about our Program?

- | | | |
|---------------------------------------------|-----------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Friend or Relative | <input type="checkbox"/> Health Care Provider | <input type="checkbox"/> Channel 93 |
| <input type="checkbox"/> WIC Office | <input type="checkbox"/> Personal Contact | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Program Brochure | <input type="checkbox"/> Other Specify _____ | |

PARENT CONSENT FORM

Child's Name _____

I hereby give the Sicangu Lakota Oyate Head Start/Early Head Start Program Staff the authorization to: (circle one)

EDUCATION SERVICES

1. Release my name, telephone number and/or address to other parents for the purpose of Communicating about specific program activities.	Yes / No
2. Include my child on local field trips (fire department, post office, library, elementary schools, day Care, Halloween activities) Child must be supervised by the parent, guardian, and other responsible Adult during home visits, field trips and socialization activities	Yes / No
3. Transport my child for all program purposes. HS/EHS will ensure that children are safely secured in Their seats and assist them with buckling seat belts.	Yes / No
4. Include information about my child/family on our Program Face Book page and Program website This includes photographs, child/family achievements or successes, birthdays, and all participation' In Program activities.	Yes / No
5. Observe my child in the classroom in relation to behavioral or developmental concerns, and when Needed to have an affiliated professional conduct observation.	Yes / No
6. Share developmental screen results & birth certificates with local education agencies (LEA)	Yes / No

PUBLIC RELATIONS

7. Take photographs of my child for Sicangu Lakota Oyate HS/EHS Facebook/Website, local Paper, etc.	Yes / No
8. Photograph or film me and my family, I understand the photographs and footages may be use for The purpose of publicity, illustration, and advertising for Head Start/Early Head Start.	Yes / No

HEALTH AND SAFETY

9. Indian Health Service Dental Dept. Delta Dental, SLO HS/EHS Health and Safety staff may Apply fluoride varnish to my child.	Yes / No
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Signature of Parent/Guardian: _____

PARENT CONSENT FORM CONT.

ERSEA

McKinney- Vento Act: Definition of Homeless

A homeless child or youth lacks a fixed, regular, and adequate nighttime residence, sharing the housing of others Due to the loss of housing, economic hardship, or similar reason (doubled up). Living in motels, hotels, trailer Parks, Campgrounds due to the lack of adequate alternative accommodations, living in emergency or transitional Shelters. Awaiting Foster care placement. Living in a public place not designed for humans to live. Living in cars, Parks, Abandoned buildings, substantial housing, bus or train stations. Etc.

After reading the McKinney- Vento Act, do you consider yourself homeless? (Circle) Yes / No

Are you currently living with another family? Yes / No

Please read each section then initial that you have read and understand it.

I understand that full participation is encouraged in the Sicangu Lakota Oyate Head Start/Early Head Start Program and will maximize my child's opportunities for growth. I am aware that if my Child's attendance becomes sporadic, my Family Advocate will work with me to improve my Child's attendance and that an "Attendance Contract" may be a part of the process. If at any time, My child's attendance becomes an issue my child may be put back on the waiting list.	Initial
I understand that participation in parent meetings/socializations are important growth experiences For my child. If I have trouble attending meetings/socializations my Advocate will work with me To identify and remove any barriers.	Initial

NON-DISCRIMINATION CLAUSE

It is the policy of the Sicangu Lakota Oyate Head Start/EHS Program not to discriminate based on race, sex, age, color, National origin, or disabilities in the provision of service and employment.

CONFIDENTIALITY STATEMENT

Information shared with the Sicangu Lakota Oyate Head Start/EHS Program will be kept confidential unless a parent Release is authorized in writing. These forms will be maintained in locked files. I hereby release SLO HS/EHS from All legal responsibilities or liabilities that may arise from acts that I have authorized above. I would like a copy of this Consent form.

Signature of Parent/Legal Guardian _____

PERMISSION IS VOLUNTARY, IT IS THE PARENTS RIGHT TO CHANGE CONSENT FORM AT ANY TIME.

HEAD START IS NOT A BABYSITTING SERVICE

Sicangu Lakota Oyate Head Start/Early Head Start Program Video Camera Surveillance Policy

Policy:

The Video Camera Surveillance Policy of the Sicangu Lakota Oyate Head Start/Early Head Start Program (SLOHS/EHS) is to ensure our children and employee's safety is maintained at all times. All employees and Parents must sign release authorizing video recordings for the limited purpose or classroom surveillance. This form will authorize release to law enforcement agencies (RST PD, RST Criminal Investigations, Prosecutors' office, or the FBI) by court order only.

Procedure:

1. If a child is injured on SLOHS/EHS property, the program will archive the video of the incident (if One exists) for three (3) consecutive school years.
2. Parents/guardians of the child may view the video in question upon setting up an appointment with The director of authorized representative. The video will not be released to the parents/guardians Under any circumstances absent a court order. The parent may not record the video utilizing any means Of copying.
3. If there are any accusations of abuse or neglect, the video will be forwarded to law enforcement agencies.
4. SLOHS/EHS staff members are mandatory reporters as defined by Rosebud Sioux Tribe Law & order Code (RSTLOC) §5-8-6 and subject to RSTLOC §5-8-7 and RST §5-8-8.
5. No parent will video record or photograph any child who they do not have legal custody of.

*I, _____ Parent/Legal Guardian of _____
have read and hereby agree to the above Video Camera Surveillance Policy and I release the Sicangu
Lakota Oyate Head Start/Early Head Start Program from any liability to the above policy.*

Signature of Parent/Legal Guardian: _____

**SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START PROGRAM
RELEASE OF INFORMATION 2023-2024 SCHOOL YEAR**

I, _____ give Sicangu Lakota Oyate Head Start/Early Head Start Program permission To release and/or obtain information with the understanding that the information will be used to assist our families In receiving services regarding the Family Needs Assessment activities and IEP/IFSP process. This information will Be given to the following agencies.

- Crazy Horse School
- Department of Disabilities Services
- Department of Social Services (TANF, SNAP)
- I.H.S. Environmental Health
- I.H.S Behavioral Health
- Lakota Tiwahe Center Program
- Low Income Housing Energy Program (LIHEAP)
- Maternal Child Health Program
- Mni Wiconi Water Conservation
- Rosebud Casino
- RST Child Care Program
- RST Commodity Food Program
- RST Community Services
- RST Court House
- RST Diabetes Prevention Program
- RST Personnel Dept.
- RST Vice Presidents Office
- Sicangu Nation Employment & Training Program
- Sinte Gleska University Registers Program
- Tiwahe Glu Kini Pi
- Todd County School District
- Tree of Life Ministries
- White River School District
- Winner School District

Parent/Legal Guardian

Date:

Parent/Legal Guardian

Contact Information: _____

CERTIFICATION OF DEGREE OF INDIAN BLOOD

JOHNSON O'MALLEY FUNDING

In order for the Sicangu Lakota Oyate HS/EHS Program to receive supplemental Johnson O'Malley funding to those identified as Indian students, the following information must be submitted by the Parent or Legal Guardian for certification to authorized personnel.

PLEASE COMPLETE THE ENTIRE FORM

Students Name: _____ Date of Birth: _____

Other Name (s) Used: _____

Tribe: _____ Degree of Indian Blood: _____

Enrollment Number: _____ Pending: Yes: _____ No: _____

Father's Name: _____ Date of Birth: _____

Other Name (s) Used: _____

Tribe: _____ Degree of Indian Blood: _____

Enrollment Number: _____ Pending: Yes: _____ No: _____

Mother's Name: _____ Date of Birth: _____

Other Name (s) Used: _____

Tribe: _____ Degree of Indian Blood: _____

Enrollment Number: _____ Pending: Yes: _____ No: _____

**If this child is enrolled, please attach a copy of their abstract,
If this child is not enrolled, please attach the mothers abstract.**

PERMISSION FOR RELEASE OF INFORMATION

I agree to release my child's abstract from his/her file for information to be used for entrance into the Public School System and Johnson O'Malley Program.

Parent/Legal Guardian: _____

THIS SECTION IS TO BE COMPLETED BY THE RST ENROLLMENT OFFICE

I hereby certify that I have reviewed the appropriate records available and do further certify that the degree of Indian blood of the individuals as listed on this certification form is correct.

Signature and Title of Certifying Official: _____ Date: _____

**SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START
PROGRAM
ELIGIBILITY VERIFICATION FORM
2023-2024 SCHOOL YEAR**

1. Family Name: _____

2. Child's first year _____ second _____ Third year _____ # Family Size _____

3. Family is eligible to participate in the Program: [] Yes [] No

4. Type of eligibility interview conducted: [] In person [] Telephone

5. Indicate eligibility documentation:

[] Income tax form 1040

[] Written statement from employer

[] W-2

[] Foster care reimbursement

[] TANF documentation

[] SSI documentation

[] Pay Statement

[] Unemployment

[] Public Assistance (SNAP, General Assistance,)

[] Other, if other please explain: _____

[] No Income No income form signed by parent: _____

For Office Use Only

_____ Categorically Eligible

_____ Income Eligible (under 100%)

_____ Income Eligible (101%-13%)

_____ Over-Income (over 130%)

I have carefully reviewed the documents and information I have provided with the ERSEA Manager/ERSEA Assistant and, by signing this form, certify to the best of my knowledge and belief that all information Regarding eligibility provided by me is true and accurate.

Parent/Legal Guardian Signature _____ Date _____

I have carefully reviewed the documents and information that has been provided to me by applicant, and By signing this form, certify to the best of my knowledge and belief that all information regarding Eligibility provided to me is true and accurate.

ERSEA Staff Signature _____ Date _____