



# Bismarck Public Schools Head Start & Early Head Start

Serving Burleigh, Emmons, and Kidder County

BECEP at Richholt  
720 N 14<sup>th</sup> Street  
Bismarck, ND 58501

www.bismarckschools.org  
(701) 323-4400  
Fax: (701) 323-4405

## INFORMATION & APPLICATION PROCESS

Dear Parent/Guardian:

Thank you for your interest in Early Head Start and Head Start at BECEP! Our programs are designed to develop the academic, social, emotional, and health needs of children from birth to 5 years old, and their families. Staff support school readiness by helping children possess the skills, knowledge, and attitudes necessary for success in school and for later learning in life. The Head Start approach to school readiness means that children are ready for school, families are ready to support their children's learning, and schools are ready for children. Children with disabilities are encouraged to apply.

Our programs are federally funded. Eligibility is determined using income guidelines established by the federal government. Ninety percent of families enrolled are below the federal poverty level, are homeless, in foster care, receive Supplemental Social Security (SSI), TANF and/or SNAP. Families who are within the 130% guidelines may be served **after** all families who meet the 100% poverty guidelines have been served, if space is available.

Your application **must be complete** before we can determine eligibility.

2024 Federal Poverty Guidelines		
Family Size	Family Yearly Income100%	Family Yearly Income130%
1	\$15,060	\$19,578
2	\$20,440	\$26,572
3	\$25,820	\$33,566
4	\$31,200	\$40,560
5	\$36,580	\$47,554
6	\$41,960	\$54,548
7	\$47,340	\$61,542
8	\$52,720	\$68,536
For each additional person, add \$5,380      add \$6,994		

**Early Head Start (EHS)** – serves a total of 12 expectant families, infants, and toddlers under the age of 3, in their homes over a 12-month period (48 weeks) July through June.

Prenatal – Expectant families receive a home visit one time a month or as needed to support them during their pregnancy.

Birth to 3 – Parent services are provided and focus on child development and parent education through weekly home visits. The home visitor supports the parents' ability to enhance their child's unique development through child-focused activities and experiences. Parent-child play groups are provided to promote socialization experiences for children.

**Head Start (HS)** – provides preschool to 119 children ages 3-5 years over a 9-month period from Aug./Sept. through May/June. Classroom instruction is provided for 6.25 hours (8:15-2:30) Monday through Friday. Each classroom is staffed by at least one teacher and two instructional aides. Each family will receive a minimum of 2 home visits. Families come to the center for open house and two conferences. Transportation to and from school is available.

Application Checklist on Back



## Application Checklist:

**Step 1 Complete the Application process to BECEP.** (To avoid any delays in processing your application, complete all items in step 1 of the application process.)

<input type="checkbox"/>	In-Person Interview	<b>Call to schedule an in-person appointment at 701-323-4400</b>
<input type="checkbox"/>	Proof of Age	State-Certified Birth Certificate. Child must be age eligible to enroll.
<input type="checkbox"/>	Proof of Residency	<u>One Primary Proof of Residence</u> (Examples indicated below) <u>One Secondary Proof of Residence</u> (Examples indicated below) <b>Note:</b> If you live in transitional housing (motel, campsite, car, shelter, or shared housing), you do not need to complete this item. Tell staff you are in transitional housing.
<input type="checkbox"/>	Driver's License or Photo ID of LEGAL guardian. (Proof of court appointed guardianship)	The person registering the student must be the legal parent or court-appointed guardian. Court appointed guardians must provide legal papers.
<b>To complete the application for Head Start and determine if your child is eligible, you must submit the following documents:</b>		
<input type="checkbox"/>	Proof of Income	Each parent/stepparent living in the home related to the child by blood, marriage or adoption must submit income verification from <b>ONE</b> of the following: <ul style="list-style-type: none"> <li>• 2023 Tax Statement</li> <li>• Pay stubs for past 12 months</li> <li>• TANF, Supplemental Security Income (SSI), Foster Care Income or SNAP</li> </ul>
<input type="checkbox"/>		Child support received, if applicable. Submit child support payments received over the past 12 months.
<input type="checkbox"/>	Early Head Start (EHS)/ Head Start (HS) Application	Review the application to make sure all questions are completed.

One Primary Proof of Residence (Examples: home mortgage, builder's agreement, purchase agreement, homeowner's insurance policy, Burleigh County property tax statement, or lease/rental agreement that lists the names of parents/guardians living in the rental unit, plus the manger's name and phone number.)

One Secondary Proof of Residence (Examples: bill for heat/lights, garbage/water, or cable TV dated within the last 30 days, or document from the Department of Social Services.)

*Unacceptable Proof of Residence: US mail, post office change of address, credit card/bank statement, personal taxes, medical bills, payroll checks, insurance policy, or any proof older than 30 days.*

**Step 2 Orientation Meeting.** New enrollees may be requested to complete a developmental screening and accompany the parent/guardian to the appointment. **The following documents will be needed following the Orientation appointment:**

<input type="checkbox"/>	Physical Exam	Current physical exam (including hearing and vision screening, hemoglobin, and blood lead screening) through a provider such as: your family physician, Health Tracks, or Public Health Unit
<input type="checkbox"/>	Dental Exam	Current dental exam
<input type="checkbox"/>	Immunization Record	Up-to-date immunization record

## Applicant & Family Member Information

Applicant 1 (Child 3-5 or Child 0-3)						
First	Middle	Last	Nickname	Birthday	Gender	Applicant Applying For
						<input type="checkbox"/> Early Head Start (Child: Birth to 3 yrs) <input type="checkbox"/> Head Start (Child: 3-5 yrs)
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	
Primary Health Coverage (Check all that Apply)		Medicaid Eligibility	Doctor/Medical Home	Dentist/Dental Home	Dental Coverage	
<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____		<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible			<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____	

Applicant 2 (Child 3-5, Child 0-3)						
First	Middle	Last	Nickname	Birthday	Gender	Applicant Applying For
						<input type="checkbox"/> Early Head Start (Child: Birth to 3 yrs) <input type="checkbox"/> Head Start (Child: 3-5 yrs)
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	
Primary Health Coverage (Check all that Apply)		Medicaid Eligibility	Doctor/Medical Home	Dentist/Dental Home	Dental Coverage	
<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____		<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible			<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____	

Applicant 3 (Child 3-5, Child 0-3)						
First	Middle	Last	Nickname	Birthday	Gender	Applicant Applying For
						<input type="checkbox"/> Early Head Start (Child: Birth to 3 yrs) <input type="checkbox"/> Head Start (Child: 3-5 yrs)
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	
Primary Health Coverage (Check all that Apply)		Medicaid Eligibility	Doctor/Medical Home	Dentist/Dental Home	Dental Coverage	
<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____		<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible			<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____	

Primary Adult (or Pregnant Mother Applicants)							
First	Middle	Last	Nickname	Birthday	Gender		
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:	
<input type="checkbox"/> Associate's <input type="checkbox"/> Grade 10 <input type="checkbox"/> Bachelor's <input type="checkbox"/> Grade 11 <input type="checkbox"/> Col Deg/Train <input type="checkbox"/> Grade 12 <input type="checkbox"/> Col or Adv Train <input type="checkbox"/> < Grade 9 <input type="checkbox"/> GED <input type="checkbox"/> HS Graduate <input type="checkbox"/> Master's		<input type="checkbox"/> Full Time (35+ hrs/wk) <input type="checkbox"/> Part Time (Under 35 hrs/wk) <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed		<input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Training or School <input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Biological/Adopted/Step (Circle one) <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent
<b>Email Address:</b>				<b>Phone Number:</b>			

**\* Complete below section only if applying to Early Head Start as a Pregnant Mother Applicant \***

Due Date (m/d/y):				
Primary Health Coverage (Check all that Apply)	Medicaid Eligibility	Doctor/Medical Home	Dentist/Dental Home	Dental Coverage
<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____	<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible			<input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> Combined Medicaid/ CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> State-Only Funded Insurance (Healthy Steps) <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Other: _____

Secondary Adult in the Home							
First	Middle	Last	Nickname	Birthday	Gender		
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency		
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:	
<input type="checkbox"/> Associate's <input type="checkbox"/> Grade 10 <input type="checkbox"/> Bachelor's <input type="checkbox"/> Grade 11 <input type="checkbox"/> Col Deg/Train <input type="checkbox"/> Grade 12 <input type="checkbox"/> Col or Adv Train <input type="checkbox"/> < Grade 9 <input type="checkbox"/> GED <input type="checkbox"/> HS Graduate <input type="checkbox"/> Master's		<input type="checkbox"/> Full Time (35+ hrs/wk) <input type="checkbox"/> Part Time (Under 35 hrs/wk) <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed		<input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Training or School <input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Biological/Adopted/Step (Circle one) <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent
<b>Email Address:</b>				<b>Phone Number:</b>			

Other Adult in the Home					
First	Middle	Last	Nickname	Birthday	Gender
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		<input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Child's Relationship			Custody	Check all that apply:	
<input type="checkbox"/> Biological/Adopted/Step (Circle one) <input type="checkbox"/> Grandchild <input type="checkbox"/> Other			<input type="checkbox"/> Foster <input type="checkbox"/> Other Relative	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent
<b>Email Address:</b>				<b>Phone Number:</b>	

Other Adult in the Home					
First	Middle	Last	Nickname	Birthday	Gender
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> None
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Little
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient
Child's Relationship			Custody	Check all that apply:	
<input type="checkbox"/> Biological/Adopted/Step (Circle one)	<input type="checkbox"/> Foster	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family		
<input type="checkbox"/> Grandchild	<input type="checkbox"/> Other Relative	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support		
<input type="checkbox"/> Other			<input type="checkbox"/> Teen Parent		
<b>Email Address:</b>			<b>Phone Number:</b>		

Additional Child(ren) in Home (Non-Applicant)						
First	Middle	Last	Nickname	Birthday	Gender	Living in Home
						___ yes ___no
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Little	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	

First	Middle	Last	Nickname	Birthday	Gender	Living in Home
						___ yes ___no
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Little	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	

First	Middle	Last	Nickname	Birthday	Gender	Living in Home
						___ yes ___no
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Little	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	

First	Middle	Last	Nickname	Birthday	Gender	Living in Home
						___ yes ___no
Race		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little		<input type="checkbox"/> Little	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	

## Family Information

Family Information								
Family Living Address								
Started Living at Date	Living Address			City	State	Zip	County	
Family Mailing Address								
Same as living?	Started Using Date	Mailing Address			City	State	Zip	
<input type="checkbox"/> Yes <input type="checkbox"/> No								
Phone Number(s)		Type (check one)			Note (extension or best time to call)		Opt In for Text Messages	
<i>Mother:</i>		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Father:</i>		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Other:</i>		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parental Status (check one)	Primary Language at Home	Acquiring/Learning another language in addition to English	Homeless Family	Active Duty Military	Military Veteran	Referred by Child Welfare Agency	Receiving SNAP	Receiving WIC
<input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

The BECEP Early Head Start/ Head Start Program serves children and their family's birth to age 5. The educational program is tailored to children's individual strengths and needs. It fosters self-esteem and develops cognitive, language, motor, and social skills. The comprehensive development program includes medical and dental screenings and follow-up treatment along with classroom experiences that emphasize a variety of preventive health practices. Nutritious meals and snacks are eaten in family-style settings. As the primary resource and educators of their children, parents are an integral part of the success of HEAD START. They are welcomed to volunteer and to participate in activities to help support their child's growth and development. They also have opportunities for leadership in the program by serving on the Policy Council and/or on Parent Committees. HEAD START offers support for parents by supporting opportunities for self-sufficiency. HEAD START staff and parents work together to develop parent partnership agreements that build on family strengths to realize short-term and long-term family goals.

### Fees:

HEAD START is funded through the United States Department of Health and Human Services, Administration for Children, Youth, and Families, Head Start Bureau. The program is free to those families who meet the established federal eligibility income guidelines.

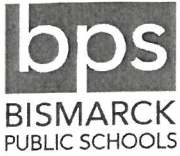
I agree to cooperate with the policies and procedures of the Early Head Start/ Head Start Program. I understand that at the beginning of the year I will be provided with a parent handbook, which includes relevant policies and procedures.

**I certify that information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination from the program if the information verified disqualifies me from eligibility.**

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Printed Name \_\_\_\_\_



**Bismarck Public School District**  
**Student Registration Form** (revised 12/2016)

**FOR OFFICE USE ONLY:**

School \_\_\_\_\_ Student # \_\_\_\_\_ Reg. ID # \_\_\_\_\_  
 Transportation Requested: Yes \_\_\_ AM Only PM Only AM/PM No \_\_\_

Student's Legal Last Name	First Name	Middle Name/Initial	Preferred Name
Date of Birth	Grade	Gender Male ___ Female ___	Student Cell Phone No.
Has this student previously attended a Bismarck Public School (including BECEP)? Yes ___ No ___			
Has this student ever been suspended? Yes ___ No ___		Has this student ever been expelled? Yes ___ No ___	
Is this student a registered offender? Yes ___ No ___			
<b>Ethnic Category:</b> Is this child Hispanic/Latino? Yes ___ No ___ Please choose all that apply to child's race: ___ African American ___ American Indian/Alaskan Native ___ Asian ___ Caucasian/White ___ Native Hawaiian/Other Pacific Islander			

**Medical/Emergency Information**

In the case of a medical emergency and I cannot be reached, I give my child's doctor or any attending physician permission to administer medical treatment. Yes ___ No ___	Physician's Name	Physician's Phone No.
Bismarck Public Schools (BPS) may give my child's Medicaid number to BPS health care providers so that the providers can bill Medicaid for services they provide my child. Medicaid No. _____	<input type="checkbox"/> Do not share my child's Medicaid number with the school. <input type="checkbox"/> Does not apply – my child is covered by another insurance. <input type="checkbox"/> My child is not currently covered by any insurance.	

**Health Information (Check ALL that apply)**

No known health problems     
  Contacts/Glasses     
  Hearing Aids  
 Ear Tubes     
  Frequent Ear Infections     
  Wheelchair  
 Life threatening allergies (list) \_\_\_\_\_     
  Other allergies (list) \_\_\_\_\_  
 Student requires Epi-pen at school? Yes \_\_\_ No \_\_\_     
 Student requires rescue inhaler at school? Yes \_\_\_ No \_\_\_  
 Asthma (\_\_\_ Inhaler Dependent)   
 Diabetes (\_\_\_ Insulin Dependent)   
 Seizure/Epilepsy (\_\_\_ Medication Required)  
 Student needs to take medication at school? Yes \_\_\_ No \_\_\_  
 Student has a medical condition school should be aware of? Yes \_\_\_ No \_\_\_ (Please list) \_\_\_\_\_

**Special Programs**

Does this student have a current Individual Education Plan (IEP) through Special Education? Yes \_\_\_ No \_\_\_  
 If yes, please indicate primary disability \_\_\_\_\_  
 Does this student have a 504 Accomodation Plan (for such things as diabetes management, ADHD, etc)? Yes \_\_\_ No \_\_\_  
 Did this student participate in a Gifted and Talented Program at their last school? Yes \_\_\_ No \_\_\_  
 Home Language (please indicate) \_\_\_ English \_\_\_ Other: \_\_\_\_\_

**Emergency Contacts – additional to parent/guardian**

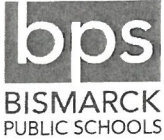
Contact #1 (Last, First Name)	Relationship to Child	Contact Phone No.
Contact #2 (Last, First Name)	Relationship to Child	Contact Phone No.
Contact #3 (Last, First Name)	Relationship to Child	Contact Phone No.

**I hereby certify that all the information contained in this form is true and accurate to the best of my knowledge.**

My relationship to the student is: \_\_\_ Parent      \_\_\_ Legal Guardian (Documentation Needed)  
 \_\_\_ Person having lawful Court Order (Order Needed)      \_\_\_ Other \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature	Date
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**Bismarck Public School District**  
**Family Residency Form** (revised 12/2016)

Parent/Guardian Contact Information				
Student Resides With (X)	Name of Parent/Guardian	Employer	Daytime Phone	Cell Phone (receive text messages)
	Mother			<input type="checkbox"/>
	Mother's Email	Mother's Address (if different than student)		
	Step Mother			<input type="checkbox"/>
	Father			<input type="checkbox"/>
	Father's Email	Father's Address (if different than student)		
	Step Father			<input type="checkbox"/>
	Guardian			<input type="checkbox"/>
	Guardian's Email			
	Guardian's Spouse			<input type="checkbox"/>

Is this a single-parent household? Yes \_\_\_ No \_\_\_

Is parent/step parent/guardian a registered offender? Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_

**Primary address where child(ren) live/reside:**

Physical Address	_____				
	Street	Apt #	City	State	Zip

**Address where school information should be mailed: (if different than physical address)**

Mailing Address	_____				
	Street	Apt #	City	State	Zip

**Where is your child/family currently living (Federal law NCLB mandates that we ask this question) – Please check the appropriate box:**  
 \_\_\_ Single family permanent residence in Bismarck (house, apartment, condo, etc.)    \_\_\_ Living in a temporary residence while building or looking for a home  
 \_\_\_ Unaccompanied Youth    \_\_\_ Doubled-Up (sharing housing with another families/individual due to economic hardship)    \_\_\_ Motel/Hotel  
 \_\_\_ In a shelter or transitional housing program    \_\_\_ Unsheltered (Car/Campsite)    \_\_\_ Foster Home    \_\_\_ Awaiting Foster Care Placement  
 \_\_\_ Other: \_\_\_\_\_

**Child(ren) ages birth to 21 living in home other than parent/guardian**

Name	Date of Birth	Relationship to You	Name of School (if enrolled)

I hereby certify that all the information provided on this form is true and complete to the best of my knowledge. I understand that providing false information on this form or in conjunction with this form may result in the Bismarck Public School District withdrawing my child's enrollment in the Bismarck Public Schools.

Signature of Parent or Legal Guardian	Date
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