



Bismarck Public Schools
Head Start & Early Head Start
 Serving Burleigh, Emmons, and Kidder County

BECEP at Richholt
 720 N 14th 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 by using income guidelines established by the federal government. Ninety percent of families enrolled are below the federal poverty level, are homeless, in foster care and/or receive public assistance. 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.

2022 Federal Poverty Guidelines		
Family Size	Family Yearly Income 100%	Family Yearly Income 130%
1	\$13,590	\$17,667
2	\$18,310	\$23,803
3	\$23,030	\$29,939
4	\$27,750	\$36,075
5	\$32,470	\$42,211
6	\$37,190	\$48,347
7	\$41,910	\$54,483
For each additional person, add \$4,720 add \$6,136		

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 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 on a limited basis.

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	Call to schedule an in-person appointment at 701-323-4400
<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.) <u>Note:</u> 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.
<input type="checkbox"/>	Student Registration Form	(Attached)
<input type="checkbox"/>	Family Residency Form	(Attached)
To complete the application for Head Start and determine if your child is eligible, you must submit the following documents:		
<input type="checkbox"/>	Proof of Income	Submit income from ONE of the following sources: <ul style="list-style-type: none"> • 2021 Tax Statement • Pay stubs for past 12 months • TANF, Supplemental Security Income (SSI), or Foster Care Income
<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 manager'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 Residents: 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) <input type="checkbox"/> Early Head Start - Expectant Mother
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) <input type="checkbox"/> Early Head Start - Expectant Mother
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
Email Address:				Phone Number:			

* 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
Email Address:				Phone Number:			

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
Email Address:				Phone Number:	

Other Adult in the Home						
First	Middle	Last	Nickname	Birthday	Gender	
Race		Hispanic	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		
Email Address:				Phone Number:		

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	ZIP	City	State	County			
Family Mailing Address								
Same as living?	Started Using Date	Mailing Address	ZIP	City	State			
<input type="checkbox"/> Yes <input type="checkbox"/> No								
Phone Number(s)		Type (<i>check one</i>)		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 (<i>check one</i>)	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 ___			
Ethnic Category: 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
---------------------------------------	------