ONEIDA
A good mind. A good heart. A strong fire.

Oneida Head Start

Three Sisters Site: 2801 W. Mason, Green Bay, WI
NHC Site: N7210 Seminary Rd., Oneida, WI

Head Start Offers:

A Safe & High-Quality Pre-School Learning Environment
Kindergarten Readiness Skills
Field Trips *Parent Education* *Oneida Language* *Transportation*
USDA Approved Meals *Family Fun Events* *Family Support/Referrals*

HOW DO I APPLY FOR HEAD START?

- ✓ **Pick up an application at the Three Sisters or NHC sites.**
- ✓ **After you complete the application Call** 496-5200 to schedule and complete an application interview. Once the interview is completed and the required documentation is submitted, the application is processed, and a letter of acceptance will be mailed. If the program is full a waitlist letter will be mailed.

Applications must include the following to determine Head Start Program Eligibility:

- ✓ Tribal Enrollment Verification (tribal I.D. or Enrollment Letter). Children from families from which a child of a family member, or member of the same household is a member of an Indian tribe are eligible to enroll in HS regardless of income. Your child must live within the program service area (Oneida Reservation and Green Bay).

If you do not have tribal enrollment verification, please provide any of the following:

- ✓ Public Assistance: TANF/W2, Social Security, etc. provide copy of award letter or evidence of benefit. Foodshare/SNAP recipients provide copy of card or copy of benefit award letter.
- ✓ Foster Child: if the applicant is a foster child, you must provide placement/guardianship verification.
- ✓ Homelessness: if the applicant is homeless, you will be asked to sign a self-declaration form for this purpose.
- ✓ Zero Income: if the family has zero income you will be asked to sign a self-declaration form for this purpose.

Medical Information: Provide verification of up-to-date annual physical & dental if your child is accepted for enrollment.

Selection Criteria:

Head Start also considers the following special needs to prioritize applicants in addition to tribal membership: public assistance, foster, homeless or zero income, parental substance misuse, child protection involvement, parent mental health concerns, domestic/partner violence, or incarcerated parent.

Please Note: Space is limited, so please complete your application & enrollment interview for early consideration. An incomplete application (without verification documents) will not be accepted & will delay your child's HS enrollment. Site selection for Head Start applicants will be based upon the location of the child's residence & center bus routes.

Oneida Head Start:
920-496-5200 (3 Sisters Site)
920-869-4369 (NHC Site)
Oneida Early Head Start:
920-490-3943
Mailing Address:
P.O. Box 365 Oneida, WI 54155

Oneida Head Start/Early Head Start Program Application

2025–2026

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Application for: Head Start □ Early Head Start: Home Based □ Center-Based □

APPLICANT (Child)				
CHILD FIRST NAME (PLEASE PRINT)	M.I.	LAST	D.O.B.	Child Lives With
			___/___/____	Mom □ Dad □ Both Parents □ Other: _____
GENDER: Male □ Female □	RACE □Native American/Alaskan Native □White □Asian □Black/African □Multi Racial/Biracial □Hawaiian/Pacific Islander		HISPANIC? Yes□ No□	

CHILD HEALTH INFO				
Child Primary Health Coverage	Badgercare □	Private Health Ins. □	Medicaid □	No Insurance □
Child Primary Dental Coverage	Badgercare □	Private Health Ins. □	Medicaid □	No Insurance □
Child Medical Clinic (medical home):		Child Dental Clinic (dental home):		

CHILD TRIBAL ENROLLMENT STATUS

Is the child an enrolled member of the Oneida Tribe? Yes □ No □ **OR** eligible for enrollment in the Oneida Tribe? Yes □ No □
OR an Oneida tribal member descendent? Yes □ No □

OR

If the child is not Oneida (enrolled, eligible for enrollment or descendent) then complete the section below for other Tribe:
Child an enrolled member of a federally recognized tribe Tribe: _____ **OR**
Child eligible for enrollment in a different federally recognized tribe Tribe: _____ **OR**
Child a tribal member descendent Tribe: _____ Child is **Not** a Tribal Member **or** Descendent □

PRIMARY ADULT/PARENT/GUARDIAN						
First Name (please print)	M.I.	Last Name	D.O.B.	Gender		Tribal Affiliation
				Male □ Female □		
Living Address	Apt.	City	State	Zip	County	Phone (Home & Work)
						____/____/____ ____/____/____
Mailing Address (if different)	Apt.	City	State	Zip	County	Email Address (Please Print)

Race	Hispanic
American Indian/Alaska Native □ Asian □ White □ Multi-Racial □ Black/African American □ Hawaiian/Pacific Islander□	Yes □ No □

Highest Level of Ed. Completed	Employment Status	Child's Relationship	Custody	Check all that Apply:
□Associate's/Vocational/ Some College □Advanced Degree, or Bachelor's □Less than HS Graduate □HS Graduate or GED	□Full Time □Full Time & Trng. □Part Time □Part Time & Trng. □Seasonal □Unemployed □Training or School □Retired or Disabled	□Biological/Adopted/ Step □ Grandchild □ Other Relative □Foster □Other_____	□ Yes □ No	Lives with Family: □Yes □No Provides Financial Support: □Yes □No

SECONDARY ADULT/PARENT/GUARDIAN						
First Name	M.I.	Last Name	D.O.B.	Gender		Tribal Affiliation
				Male □ Female □		
Living Address	Apt.	City	State	Zip	County	Phone (home & work)
						____/____/____ ____/____/____

Mailing Address (If Different)	Apt.	City	State	Zip	County	Email Address (please print)

Race	Hispanic
American Indian/Alaska Native □ Asian □ White □ Multi-Racial □ Black/African American □ Hawaiian/Pacific Islander□	Yes □ No □

Highest Level of Ed. Completed	Employment Status	Child's Relationship	Custody	Check all that Apply:
□Associate's/Vocational/ Some College □Advanced Degree, or Bachelor's □Less than HS Graduate □HS Graduate or GED	□Full Time □Full Time & Trng. □Part Time □Part Time & Trng. □Seasonal □Unemployed □Training or School □Retired or Disabled	□Biological/Adopted/ Step □ Grandchild □ Other Relative □Foster □Other_____	□Yes □No	Lives with Family: □Yes □No Provides Financial Support: □ Yes □No

OTHER FAMILY MEMBER INFORMATION

Additional Children in Family Household (Non-Applicant) (Dependents Supported by Parent/Guardian)

First Name	Last Name	D.O.B.	Gender
		____/____/____	Male □ Female □
		____/____/____	Male □ Female □
		____/____/____	Male □ Female □
		____/____/____	Male □ Female □
		____/____/____	Male □ Female □

FAMILY STATUS

Parental Status	Primary Language at Home	Child Experiencing Homelessness	Either Parent/Guardian Active-Duty Military	Receiving Food Share/SNAP	Child Applicant Receives WIC
One Parent Family □ Two Parent Family □	English □ Spanish □ Other: _____	Yes □ No □	Yes □ No□ Veteran? Yes □ No □	Yes □ No □	Yes □ No □

FAMILY INCOME (Relevant time period is last 12 month; Goss (Before Taxes); Income Verification: Tax Form 1040, W-2, Pay Stubs, etc. Types of unearned income to report: Per Capita, Child Support, Unemployment, Foster Care Payment, Public Assistance, Veteran's Benefits, SSI, etc.

TANF Status: Yes □ No □ Formerly on TANF/Not now □ **SSI** Status: Yes □ No □

Income Verified By: Verification Date:

Family Member Name:	Amount	How Often? Per Wk./Bi-weekly/ Monthly	Type (job, child support, SSI, W-2, TANF, per-capita, etc.)	Annual Amount	Note:

Income Notes: (Office Use): #in Family: _____ Total Eligibility Income: _____

Certification: I certify that this information is true and correct and that all income is reported. I understand that this information is being given to determine eligibility for a federal program and will be verified for accuracy. Providing false information may result in non-acceptance. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature_____ Date____/____/____

EMERGENCY CONTACTS

Name (Please Print)	Relationship to Child (grandparent, aunt, uncle, family friend, etc.	Phone #	Emergency Contact	Release to
		____/____/____	Yes □ No □	Yes □ No □
		____/____/____	Yes □ No □	Yes □ No □
		____/____/____	Yes □ No □	Yes □ No □
		____/____/____	Yes □ No □	Yes □ No □

<table>
<tr><th colspan="3">SELECTION CRITERIA</th></tr>
<tr><td colspan="3">HS/EHS must enroll children and families who are most in need of HS/EHS services. In addition to income, HS/EHS prioritizes applicants based on the approved program selection criteria listed below:</td></tr>
<tr><td>Parental Status</td><td colspan="2">Child Tribal Enrollment Status:
Info must be provided to verify status</td></tr>
<tr><td>□ Single Parent □ Teen Parent</td><td colspan="2">□ Oneida Tribe Enrollment or Eligible for Enrollment (child)</td></tr>
<tr><td>□ Guardian/Relative/Non-Relative Foster or Kinship Care Provider</td><td colspan="2">□ Oneida Tribe Descendent (child)</td></tr>
<tr><td>Family Status</td><td colspan="2">□ Other Tribe Descendent (child)</td></tr>
<tr><td>□ Child Protective Services (current or history of)</td><td colspan="2">Disability Status (Child)</td></tr>
<tr><td>□ Substance Misuse (current or history of)</td><td colspan="2" rowspan="2">Certified IEP or IFSP □Yes □No
Has or is your child receiving services from a school district?
If yes, school district? _____</td></tr>
<tr><td>□ Foster Child (applicant)</td></tr>
<tr><td>□ Homelessness</td><td colspan="2">EHS Center-Based Only:</td></tr>
<tr><td>□ MH Concerns (primary caretaker)</td><td colspan="2">□ Lack of Childcare Resources (Primary Caretaker)</td></tr>
<tr><td>□ Domestic/Partner Violence (current or history of)</td><td>□ Child Protection</td><td rowspan="4">□ Suspected Disability or Developmental Delay

□ Certified IFSP (Disability)
Type of Disability:
_____</td></tr>
<tr><td rowspan="3">□ Parent currently incarcerated</td><td>□ Unemployed (primary caretaker)</td></tr>
<tr><td>□ Lack of informal supports</td></tr>
<tr><td>□ Cognitive Delays (Primary Caretaker)</td></tr>
<tr><td>□ Receiving TANF/W2/SSI</td><td colspan="2" rowspan="2"></td></tr>
<tr><td>□ Child currently/previously enrolled in Oneida Early HS</td></tr>
</table>

Please Contact Head Start/Early Head Start to **schedule an application interview**
At the time of the interview bring **completed application** and **income verification** to complete the application process

Office Use Only: Type of Eligibility: Income below 100%□ 101-130%□ Public Assistance (includes SNAP) □ Homeless □ Foster Child/Kinship □
Other: Disability □ Extended Duration □ Site: 3 Sisters □ NHC □ EHS: HB □ CB □

Nutrition Assessment- Head Start

Child Name: _____

Date of Birth: _____

Head Start and Early Head Start

1. Does your child have any special dietary needs (due to religious, personal beliefs, at home diet, and/or medical needs like an allergy)? Circle one: Yes No
2. If your child has a food allergy/intolerance please list:

   _____
3. If any other special dietary needs please list here:

   _____
4. Do you feel like your child is not eating/drinking enough of any of the following (please circle):
   a. Protein rich foods (poultry, eggs, beans, etc)
   b. Vegetables
   c. Fruits
   d. Water
   e. Whole grains
5. Approximately how many cups of these beverages does your child drink in a day?
   a. _____ juice/kool-aid etc
   b. _____water
   c. _____milk
   d. _____soda
   e. _____ Other - please list _____
6. How many meals does your child eat per day? _____
7. Do you have any concerns about what/how your child eats?

   _____

   _____

   Would you like to speak to a registered dietitian about this (please circle)? Yes No
8. Do you receive WIC (please circle)? Yes No

Early Head Start

1. Please circle if your child gets nutrition from any of the following
   a. Breastmilk b. Formula c. combination of both d. weaned from both
2. If formula fed, what brand do you use? _____
3. How often is your child fed a day (if formula/breastfed)? _____times
4. Which of the following does the child use to eat or drink (circle all that apply)?
   Breast Bottle Cup Fingers Spoon Fork
5. What types of food do you feed your child (please circle)
   Family/Table Food Jarred Baby Foods Both None

PO Box 365 • Oneida, WI 54155-0365
oneida-nsn.gov

ONEIDA

Head Start/Early Head Start
Health History

Child Name:		**Birth Date:**	
Gender:	Male / Female	**First Day of Attendance:**	

Medical History: (Circle all that apply)

Anemia	Asthma	ADHD	Autism (ASD)
Bleeding problems	Diabetes	Hearing Problems	Heart Condition
High Lead Level	Seizures	Tuberculosis	Vision Problems
Other:			

Health Care	
Name of Physician/Provider	
Name of Clinic/Office	
Date of child's most recent health check-up/well child exam/physical	

Dental Care	
Name of Dentist	
Name of Clinic/Office	
Date of child's most recent dental exam	

Does your child have any allergies?_____

Has your child had any serious illnesses, injuries or surgeries in the past?_____

_____

Will over-the-counter OR prescription medication be needed at Head Start-Early Head Start?
(including but not limited to diaper cream, asthma inhalers, allergy medications, etc.)

No / Yes *

**Additional paperwork must be completed and signed by a health care provider before the medication can be given at HS/EHS.*

Is there any other information we should know about your child's health or special needs?

_____

Parent/Guardian		**Date**	

Review dates: _____ _____ _____ _____ _____