



AGENCY SELECTION CRITERIA CHECKLIST

COMPLETED APPLICATION PACKET MUST BE POSTMARKED BY FEBRUARY 6, 2015

All of the following criteria **must be satisfied** in order to participate in the Office of Head Start National Center on Health training program. Please check each box to indicate that your agency satisfies each requirement.

- Early Head Start program that has an existing partnership with a Child Care Provider in their community (Center or Family based).
- Early Head Start program that has **demonstrated ability to develop new initiatives** and develop them from start to finish.
- Early Head Start program that has a history in data collection and tracking of data for reporting other than for the reports required by the Federal Government (ACF).

Once the above qualifications have been met, the following requirements must be committed to. Please check each box to indicate your agency's commitment.

- The Agency must create a team of 5 staff members to help manage the health training program. Three staff members from the Early Head Start program and two staff members from the Child Care Center or Family Child Care representing the following roles (titles may vary by agency):

Required team members:

- EHS Director
- Social Services Lead
- Health Services Lead
- Child Care Center Director/Family Child Care Provider
- Child Care Center Staff Member/Family Child Care Staff Member

**Other team members may be designated to be part of Project Team once training team returns to local agency.*

- The Training Team must attend the Train-the-Trainer in St. Louis, MO, April 13-14, 2015; conduct parent training(s) within your program and follow up with participating families for reinforcement.**
- The Director of the Early Head Start program must identify a Project Coordinator that has the responsibility of reporting to the UCLA Health Care Institute team for the project. The Project Coordinator will be the primary contact for the project.



EARLY HEAD START PROGRAM INFORMATION

Name of Program: _____

Name of Agency (if different): _____

Region: _____ Grantee Delegate

Program Street Address: _____

City/State/Zip Code: _____

Telephone: _____ Fax: _____

Email Address: _____ Program Website: _____

Organization Type (check one):

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> CAP/CAA | <input type="checkbox"/> Single Purpose | <input type="checkbox"/> Local Government |
| <input type="checkbox"/> Non Profit | <input type="checkbox"/> Tribal Government | <input type="checkbox"/> School System |

Other: _____

SCOPE OF EARLY HEADSTART PROGRAM:

Total Number of Children _____

0-11 months old _____

1-2 years old _____

Number of Staff _____

Number of Centers _____

Home-Based Areas _____

Number of Families _____

Child Care Homes _____



Child Care Center or Family Child Care Partner Information

Name of Child Care Center/Family Child Care Partner:

Program Street Address: _____

City/State/Zip Code: _____

Telephone: _____ Fax: _____

Email Address: _____ Partner Website: _____

OTHER INFORMATION

TYPE OF COMMUNITY (check one): Rural Urban Rural/Urban Suburban

SERVICES (check all that apply): Preschool Early Head Start Year-round

PLEASE INDICATE THE NUMBER OF CHILDREN IN YOUR PROGRAM WHO ARE IDENTIFIED BY THEIR PARENTS AS:

_____ African American

_____ Caucasian

_____ Hispanic/Latino

_____ Asian/ Pacific Islander

_____ American Indian Alaska Native

_____ Other

PLEASE INDICATE THE TOP TWO LANGUAGES SPOKEN BY YOUR FAMILIES:

1. _____

2. _____

PLEASE LIST THE MAJOR EMPLOYERS OF YOUR PARENTS IN YOUR AREA:

1. _____

2. _____

3. _____

This document was prepared under Grant #90HC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Health.



TEAM MEMBER NAMES:

PLEASE INDICATE WHO THE PROJECT COORDINATOR WILL BE BY CIRCLING THE NUMBER NEXT TO HIS/HER NAME.

Early Head Start Program Staff

1. Name: _____

Title: _____

Email: _____

Phone: _____

2. Name: _____

Title: _____

Email: _____

Phone: _____

3. Name: _____

Title: _____

Email: _____

Phone: _____

CHILD CARE PARTNER/FAMILY CHILD CARE PROVIDER STAFF

4. Name: _____

Title: _____

Email: _____

Phone: _____

5. Name: _____

Title: _____

Email: _____

Phone: _____



STATEMENT OF INTENT
(TO BE COMPLETED BY THE EARLY HEAD START DIRECTOR)

Please limit your answers to a total of two typed pages and attach your statement to this page.

- Describe an initiative or program that you started and completed at your agency with your child care/family child care provider. What were the overall results/impact of these initiatives on your agency and the community at large? How did you involve your staff, families and community partner?
- What are the major challenges facing your community and your program? What are you doing to respond to these challenges and/or what would you like to do to meet these challenges? How will participating in the UCLA Health Care Institute benefit your children/families/community that you serve?

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February 6, 2015

**INCLUDE: Selection Criteria Checklist
Application for Participation
Statement of Intent
Commitment Form**

**MAIL TO: I CAN
c/o CMCA Head Start
Attn: Trisha Wright
807B North Providence Rd.
Columbia, MO 65203**



COMMITMENT FORM

TRAINING TEAM

By applying to participate in the UCLA Health Care Institute program, I understand that I am making the following commitments upon my acceptance to the program:

- ◆ To be a part of the UCLA Health Care Institute program for at least 1 year and train **at least 100 parents per year (*Accepted programs serving less than 100 families will be asked to sign a commitment guaranteeing a minimum number of families trained).**
- ◆ To work cohesively within the Training Team (the 5 team of staff members) throughout the duration of the study.
- ◆ To submit requested data, program progress, successes and challenges relating to participation in the UCLA Health Care Institute.
- ◆ To meet deadlines as established by the UCLA Health Care Institute team and to communicate regularly with UCLA and the I CAN team.
- ◆ To obtain support from policy council and board of directors.
- ◆ Under the guidance and training of the UCLA Health Care Institute and I CAN partners, will develop and implement an effective system to engage families and staff.

EHS Director (Team Member #1)

Child Care Center Director/Family Child Care Provider (Team Member #4)

EHS Social Service Lead (Team Member #2)

Child Care Center/Family Child Care Staff (Team Member #5)

EHS Health Service Lead (Team Member #3)

POLICY COUNCIL AND BOARD MEMBERS

By signing this application, I understand and accept the above commitments made by the team. I further agree to make the following personal commitment:

- ◆ I will work with and support the team from my Head Start program to effectively run the Health Care training program at our agency.

Policy Council President

Board Chair/President

Date: _____

Date: _____

[Return with application by February 6, 2015](#)