



CITY OF CHICAGO
DEPARTMENT OF FAMILY
AND SUPPORT SERVICES

Head Start/Early Head Start Scope of Services

Delegate Agency Name: _____ P.O. #: _____

Main Office Address/Zip Code: _____

Program Type: Head Start *or* Early Head Start

Check appropriate agency type(s):

- Community Action Agency(CAA) Private/Public Non-Profit (i.e. church)
 Government Agency (Non-CAA)
 Private/Public For Profit Charter School System

Program Staff	Name of Program Staff	Contact Number	Email Address
Executive Director	_____	(____) ____ - ____	_____
HS/EHS Program Director	_____	(____) ____ - ____	_____
Fiscal Officer	_____	(____) ____ - ____	_____
Policy Committee Chairperson	_____	(____) ____ - ____	_____
Board Chairperson	_____	(____) ____ - ____	_____

Approval Signatures for Head Start/Early Head Start Scope of Services

Delegate Agency Executive/Program Director _____ Date _____

DFSS _____ Date _____



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Program Approach

1. Check your program options: HS EHS
2. Check your program models: CB/FD CB/HD HB FCCH
3. What are the service days for each of these program models: _____CB/FD _____CB/HD _____HB
_____FCCH
4. What is the beginning date for this program year and the end date for this program year for each of these program models: Full Year: _____/_____/_____ to _____/_____/_____
Part Year: _____/_____/_____ to _____/_____/_____
5. List below the number of days per month the program be closed for pre-service days, weekday holidays and other non-service days:

December 20__:	April 20__:	August 20__:
January 20__:	May 20__:	September 20__:
February 20__:	June 20__:	October 20__:
March 20__:	July 20__:	November 20__:
Total Number of Non-Service Days:		

Licensing Status:

1. Are all City and State licenses are current? Yes No ; if no, please list facilities with licensing issues state or city.



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Organizational Structure

1. Attach a copy of the current organizational chart.
2. Attach a copy of the board membership list. The list identifies the members with following areas of expertise:
 - expertise in early childhood development & education Yes No
 - expertise in financial accounting & fiscal management Yes No
 - a licenses attorney family with matters that come before a governing body
Yes No
 - A former or current Head Start parent Yes No
 - Board membership includes more than these four members and areas of expertise
Yes No If you answer no to any of these statements, explain why:
3. Attach a copy of the current policy committee membership list.

Monitoring

1. How does the agency monitor program expenditures and ensure that appropriate fiscal controls/records are in place?



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Staff/Parent Development

1. All Head Start/Early Head Start staff are listed in COPA HR: Yes No

If no, explain why:

2. All HS/EHS Staff paid from these grants have a professional development plan in place:

Yes No ; If no, explain why not:

3. There is a projected parent activity calendar/plan developed for the upcoming program year:

Yes No ; If no, explain why:

If yes, attach a copy.



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POLICY COMMITTEE APPROVAL PAGE

Head Start

Early Head Start

This is to certify that we, the undersigned Policy Committee members, have met, discussed, reviewed, and approved the agency's Head Start and/or Early Head Start Scope of Services and Budget. The subsequent approval date was ____/____/_____.

A quorum for this policy committee is: _____.

Policy Committee Members Name (Print)	Policy Committee Member's Signature



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Delegate Agency Name: _____ P.O. #: _____

Contact Information of the person who completed the Scope of Services

Name/Title	
Address/Zip Code	
Contact Number	(____) ____-____
Email Address	

Contact Information of the person who completed the Budget

Name/Title	
Address/Zip Code	
Contact Number	(____) ____-____
Email Address	