CITY OF CHICAGO
DEPARTMENT OF FAMILY
AND SUPPORT SERVICES

Early Head Start Expansion 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 Scope of Services

Delegate Agency Executive/Program Director_____ Date_____

DFSS_____ Date_____

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Program Approach

1. Check your program options ☐EHS-Expansion
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 Early Head Start Expansion staff are listed in COPA HR: Yes☐ No☐

   If no, explain why:

2. All EHS-EXP 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

✔ **EHS Expansion**

This is to certify that we, the undersigned Policy Committee members, have met, discussed, reviewed, and approved the agency's **Early Head Start Expansion** 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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Early Head Start Expansion Scope of Services

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	