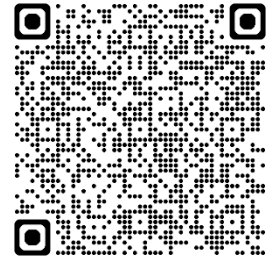




Northcoast Children's Services Job Openings



Lead TEACHER, NCSITC, Crescent City

The Lead Teacher is responsible for the development and implementation of all classrooms activities. The Team Teacher will work closely with the Center Director/Teacher to coordinate services for children, families, and the program. They must maintain the program consistency regarding rules, individualization for the children, and program expectations. Must have 12 core in ECE/CD (with 3 units in Infant/Toddler Development or Curriculum), and meet Associate Teacher Level on the Child Development Permit Matrix. *F/T hrs./wk. \$23.62-\$26.04/hr. Open Until Filled.*

TEACHER, NCSITC, Crescent City (EHS)

The Teacher is responsible for the development and implementation of classroom activities. The Teacher must be enthusiastic and energetic about working with young children, parents and other staff members. Must have 12 core units in ECE/CD (with 3 units in Infant/Toddler Development or Curriculum), meet Associate Teacher level on Child Development Permit Matrix or higher.

F/T 40hrs. \$22.48-24.78/hr. Open Until Filled

Family Worker, Crescent city

Works in collaboration with teachers, will provide services to families in the Head Start Center Based program. In partnership with parents, the Family Worker develops mutually trusting relationships, acts as an advocate for families, and provides support services as needed. The Family Worker will assist families in determining their needs and in identifying and developing goals to meet those needs. B.A. Degree from a four-year college or university in social work, psychology, child development or a related field desired. One year case management or home visiting experience or working with at-risk families.

P/T hrs./ Mon-Fri/ \$21.93-\$24.18 Open until filled

COOK, Blue Lake Temporary

The Cook implements the cycle menu in accordance with NCS policies, procedures and established practices. Purchases and prepares food, completes Child Care Food Program paperwork. Paperwork includes menu production records, monthly adjustment sheets, food transport records, inventories, cycle menus, attendance sheets and food purchase receipts, and supports center staff with nutrition activities in the classroom. This is a non-exempt position.

F/T – 32 hrs./week \$19.87

TEACHER, CRITC Temporary

The Teacher is responsible for the development and implementation of classroom activities. The Teacher must be enthusiastic and energetic about working with young children, parents and other staff members. Must have 12 core units in ECE/CD (with 3 units in Infant/Toddler Development or Curriculum), meet Associate Teacher level on Child Development Permit Matrix or higher.

F/T 40hrs. \$22.48-24.78/hr. Open Until Filled

Lead Teacher, Fortuna Toddy Thomas, Temporary

The Lead Teacher is responsible for the development and implementation of all classrooms activities. The Team Teacher will work closely with the Center Director/Teacher to coordinate services for children, families, and the program. They must maintain the program consistency regarding rules, individualization for the children, and program expectations. Must have 12 core in ECE/CD (with 3 units in Infant/Toddler Development or Curriculum) and meet Associate Teacher Level on the Child Development Permit Matrix.

F/T hrs. \$23.62-\$26.04/hr. Open Until Filled.

Food Program Manager Successor (In Training)

Under the direction of the Food Program Manager, The Food Program Manager Successor (a training position) will learn all duties and responsibilities required of the Food Program Manager position. Responsibilities include understanding CACFP regulations, Head Start/ Early Head Start Performance standards, training food service personnel regarding regulations, paperwork and shopping, conducting CACFP Site Monitoring, monitoring sites per state food safety and sanitation laws and regulations, reviewing and processing CACPF Menu Production Records for compliance, submitting the monthly CACFP claim for reimbursement, writing yearly CACFP application and additional yearly updates. This is an hourly position while in training and upon successful completion of the 6-month introductory period will result in transition to the Food Program Manager position,

F/T M-F \$31.76-\$35.02/hr.

NCS

**ACTIVE
PARENTING: THE
FIRST FIVE YEARS**

PARENTING WORKSHOPS

In-Person (1000 B St, Eka) or on Zoom

English Meeting id: 879 9111 6452

Passcode 1266


- ✓ Dinner and childcare are provided for those who register
- ✓ Childcare is limited to 24 children (8 infant/toddlers & 16 pre-K 4-10yrs)
- ✓ Dinner is at 5pm, workshop is 5:30-7:30pm

THURSDAYS, MARCH 13TH, 20TH & 27TH

5PM-7:30PM

**JEFFERSON HEAD START, 1000 B ST EKA OR ON
ZOOM**

**CONTACT BRENDA TO REGISTER: LEAVE A
MESSAGE FOR: HOW MANY ADULTS, NAMES/
AGES OF CHILDREN FOR CHILDCARE, A CONTACT
NUMBER**

 1-707-825-1310

 bbluntzer@ncsheadstart.org



NCS

**ACTIVE
PARENTING: THE
FIRST FIVE YEARS**

Crianza de los hijos talleres de trabajo

*En persona (1000 B St, Eka) o por
Zoom*

Reunión en español zoom id: 836 4861 1954

Código de acceso: 850880




- ✓ Se proporciona cena y cuidado de niños para quienes se registren
- ✓ El cuidado infantil esta limitado a 24 niños (8 bebés 0-3 años y 16 pre-k de 4 a 10 años)
- ✓ La cena es de 5pm, el talleres es de 5:30-7:30pm

JUEVES, MARZO 13TH, 20TH & 27TH

5PM-7:30PM

**JEFFERSON HEAD START, 1000 B ST EKA OR ON
ZOOM**

Para registrarse envíe un correo electrónico o llame deje
un mensaje para Brenda
Cuantos adultos
nombres y edades de los niños para edl cuidado infantil
numero de ontacto

 1-707-825-1310

 bbluntzer@ncsheadstart.org



BILINGUAL CUENTOS BILINGÜES STORYTIME

Únase a nosotros en la biblioteca principal de Eureka para la hora de cuentos bilingües, donde Cantamos, Bailamos y Leemos cuentos en Español e Inglés.

Todos los Viernes a las 11:30 a.m.

Join us at the Eureka Main Library for Bilingual Storytime where we Sing, Dance, & Read stories in Spanish and English.

Every Friday at 11:30 a.m.



1313 Third St., Eureka

www.humlib.org

707-269-1910



HUMBOLDT COUNTY
Library

All are welcome, best designed
for ages 2-6 years old.
The event is for 30 minutes.

Todos son bienvenidos,
mejor diseñado para edades 2-6 años.
El evento dura 30 minutos.



HAND IN HAND PARENTING

FREE CLASS SERIES

A SUPPORTIVE GROUP TO
LEARN MORE ABOUT
HAND IN HAND'S
5 SIMPLE TOOLS TO
SUPPORT BIG EMOTIONS
AND BRING MORE JOY
TO YOUR FAMILY

TUESDAY MORNINGS

MARCH 4-APRIL 8

BLUE LAKE
COMMUNITY RESOURCE CENTER

FOR MORE INFORMATION
AND TO RESERVE YOUR SPOT

EMAIL:
ELENAMACKCONSULTING@GMAIL.COM



IS IN FORTUNA!!!

The Humboldt Workforce Coalition is excited to announce that we will have a team member in Fortuna the 1st and 3rd Monday of each month.

Stop by the Gene Lucas Community Center between 10am and 4:30p for information about services.

We will be there March 4 and March 18

Contact Leann.Greene@humboldt.edu to make an appointment

Working together to put local people in local, skilled, living wage jobs

Client Services

How can we help you?

TIER ONE

All Job Seekers

- Computers available for job search activities
- All local area job listings available
- Create resumes, cover letters, and reference sheets using specialized software
- Fax, scan, or email potential employers
- Attend free skill trainings and job search workshops
- Take typing tests
- [REDACTED]
- Labor market data
- Free HiSET testing center
- Job fairs and MORE!

TIER TWO

Enrolled Clients

(All services in Tier 1 plus...)

- We pay for schooling and certifications*
- We pay for items needed to set you up for success-including transportation, work clothing and required supplies*
- Interview preparation and training
- Mock interviews and feedback to prepare you for employer interviews
- And MORE!

TIER THREE

Enrolled Clients

(All services in Tier 1 and Tier 2 plus...)

- Introduction to currently hiring employers*
- Paid on the job training*
- Paid work experience*
- Internships*
- And MORE!

*All paid support services based on qualification, availability and need



For more information about Humboldt Workforce Coalition:

email: HWC@co.humboldt.ca.us

phone: (707-445-7745) 2420 6th St, Eureka, CA 95501

Servicios al Cliente

Cómo le podemos ayudar?

NIVEL 1

Buscando Trabajo

- Computadoras disponibles para buscar trabajo
- Listas de trabajos locales disponibles
- Crear resumes, curriculums (CV) y hojas de referencia
- Escanear, enviar correo electrónico (email), o fax a empleadores
- Asistir a talleres gratis para desarrollar habilidades o búsqueda de trabajo

NIVEL 2

Cientes inscritos en nuestro programa

Todos los servicios de nivel 1 más los siguientes:

- Pagamos gastos escolares y certificaciones*
- Pagamos los artículos necesarios para clases o entrenamiento. Incluyendo: transporte, ropa de trabajo y más*
- Entrenamiento para entrevistas
- Simular/practicar entrevista
- Y mucho más!

NIVEL 3

Cientes inscritos en nuestro programa

Todos los servicios de nivel 1 y 2 más los siguientes:

- introducción a los empleadores actuales
- Capacitación remunerada en el trabajo*
- Experiencia laboral remunerada*
- Pasantías*
- Y más!

*Todos los servicios de financiamiento se basan en requisitos, disponibilidad y necesidad.



Para obtener más información:

correo electrónico HWC@co.humboldt.ca.us

teléfono (707-445-7745) 2420 6th St, Eureka, CA 95501

APPLY TO BECOME A CALIFORNIA EARLY CHILDHOOD CERTIFIED MENTOR



- ➤ Invest in the next generation of early childhood educators entering the workforce.
- ➤ Guide and affirm new teachers and directors' accomplishments.
- ➤ Represent the culture, language, and high caliber early care and education practices in the communities you serve.
- ➤ Impact hundreds, if not thousands, of young children 0-5, well into their future.
- ➤ Develop relationships that may last a lifetime, based on mutual trust, dignity, and respect.



California Early Childhood Mentor Program's certified Mentors:

- Earn stipends for their service
- Participate in Communities of Practice
- Engage together in Statewide Institutes
- Enjoy the peer-to-peer opportunities
- Leadership opportunities



For more information contact Dr. Susan Rosen @ susan.rosen@redwoods.edu

Deadline for application is March 1, 2025



Join Friends of the Dunes for

Nature

STORY

Time

Nature Story Time is geared for children 3-6 and their caregivers. Weekly topics focus on local flora and fauna. Each week there is a short story, kinesthetic activity, and an art project.

March 11 and April 22 will be bilingual (Spanish) story times.
Tendremos tiempo de cuentos bilingüe el 11 de marzo y 12 de abril.

March 4th - May 6th

Every Tuesday from 2:00 PM to 3:00 PM

Scan to RSVP!



¡Escanea para registrarte!

Humboldt Coastal Nature Center
220 STAMPS LN, MANILLA
www.friendsofthedunes.org



STARTS FEBRUARY 24, 2025

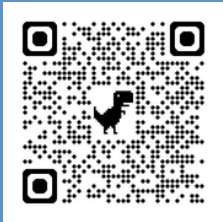
FREE
FOR CAREGIVERS
OF CHILDREN
UP TO
AGE 8

No Drama Discipline

PARENTING SERIES

Spend Time with Other Parents and Learn
Strategies To More Effectively Communicate
and Connect with Your Child

REGISTER
HERE



A six-week parenting group based on the bestselling book
No-Drama Discipline by Daniel J. Siegel and Tina P. Bryson

DATES:

Monday, February 24
Monday, March 3
Monday, March 10
Tuesday, March 18
Monday, March 24
Monday, March 31

TIME: 5:30-7:30pm



LOCATION:

Humboldt County Office of Education, 901 Myrtle Avenue, Eureka

A light dinner is provided. Childcare is available for children
ages 1-8 years. Babies younger than 12 months old
are welcome in arms. Registration is required.

Each family will receive a copy of the book *No-Drama Discipline: The Whole-
Brain Way to Calm the Chaos and Nurture Your Child's Developing Mind*



Humboldt County Office of Education

**Early Education
Department**

**For information or to register call:
Hailey at 707.613.3183 or
Ev at 707.633.3065**



Kids' Mobile Dental Van

How it Works

1. Please fill out forms **COMPLETELY**. USE INK ONLY. Return it to your child's school.
2. If you do not need to be present, we will call your child from class to complete a dental exam with X-rays. If you do want to be present, we will call to schedule.
3. A letter detailing your child's examination results and necessary treatment will be sent home.
4. Treatment will be completed during school hours.
5. In 6 months, call the Burre or Fortuna Dental Clinic for your child's next check-up.



opendoor
Community Health Centers

Contact us at: (707) 407-7713

Our Services

- Comprehensive Exam
- Cleanings
- Sealants
- White Fillings Stainless
- Steel Crowns
- Extractions
- Oral Health Education

We accept Meds-Cal/Partnership, all private insurances, and work with those without insurance. No child will be turned away due to inability to pay.

Open Door Community Health Centers Mobile Dental Program
Consent to Treatment, Payment, and Release of Information

Print Name of Child

Child's Date of Birth

What dental care do you want your child to receive?

Check the box next to each service you want for your child.

- Dental exam:** Includes dental X-rays.
- Preventive services:** Includes cleaning, fluoride treatment, sealants, and oral health education.
- Treatment of cavities:** Includes fillings, crowns, pulp/nerve treatments. *Local anesthesia may be used.*
- Extraction of baby tooth:** *Local anesthesia may be used.* If needed, one dose of children's ibuprofen may be given. We call the day before to inform you.

Note: Extraction of permanent tooth requires an additional consent

Which appointments would you like to be present for? It will take place during school hours. Please note that there is limited room on the van and you may need to wait outside nearby.

Check the box next to each service you would like to be present for.

- I do NOT need to be present for appointments.
- I want to be present for the exam.
- I want to be present for preventive services(cleanings and sealants).
- I want to be present for fillings.
- I want to be present for extractions.

Payment

If my child has dental insurance or Medi-Cal/Partnership, I agree to present their current coverage card. No child will be turned away, regardless of your ability to pay.

Additional Consents Please use the QR code to access.

Also available at <https://opendoorhealth.com/locations/burre-dental-center/mobile-dental-van/>

I agree that the following consents have been made available for my review and I agree to the terms included in these documents.

- Open Door's Notice of Privacy Practices
- Dental Material Fact Sheet
- I cannot access forms electronically and request a paper copy.



By signing below, I agree:

- I have read this consent, or had this consent read to me.
- I understand and consent to the above statements.
- I authorize Open Door Mobile Dental Program staff to provide the dental care I chose above.
- The information I provided is true and correct, to the best of my knowledge.
- I have had the opportunity to read the Dental Material Facts Sheet and Open Door's Notice of Privacy Practices.

Print name of consenting adult

Signature of consenting adult

Date
Preference
Call / Text

Adult's relationship to child

Daytime phone number

Choose One

Open Door Community Health Centers
Mobile Dental Health History

Child's Name: First: _____ Last: _____ Date of Birth: _____ Age: _____

Parent/Guardian Name: First: _____ Last: _____

MEDICAL HISTORY

Child's MRN: _____

Date of Last Medical Exam: _____ Provider Name: _____ Specialists: _____

Has your child had any of the following:

	YES/NO	
Irregular Heartbeat or Blood Pressure		
Congenital Heart Defect or Heart Surgery		
Artificial Heart Valve		
Blood Disorders (anemia, sickle cell)		
Hemophilia or Excessive Bleeding		
Cancer/Radiation/Chemotherapy		
Liver or Kidney Problems		
Thyroid Disease		
Seizures/Epilepsy		

	YES/NO	
Diabetes (high/low blood sugar)		
Behavioral or Psychiatric Treatment		
ADD/ADHD		
Autism Spectrum Disorder		
Developmental or Intellectual Disability		
Impaired Vision, Hearing, or Speech		
Frequent Sinus or Tonsil Infections		
Asthma or Breathing Problems		

Has your child ever been hospitalized? If yes, for what?

Any other problems or conditions not listed?

MEDICATIONS (include prescriptions, over-the-counter medications and inhalers)

Check here if none (use back side for additional space)

ALLERGIES

Check here if none

Date of Last Dental Exam: _____ Dentist/Clinic: _____

- | | |
|--|----------|
| • Does an adult help with brushing and flossing? | Yes / No |
| • Has the child had any unpleasant experiences in the dental or medical office? | Yes / No |
| • Has the child had any injuries to the face, mouth, or teeth? | Yes / No |
| • Does the child have any oral habits (thumb sucking, biting fingernails, etc.)? | Yes / No |
| • Has the child complained of tooth pain? | Yes / No |

Any specific questions or concerns?

Please notify us if changes occur. Appointments may be rescheduled if the child is sick or struggling to breathe through their nose.

Parent/Guardian Signature: _____

Date: _____

Legal Last Name: _____ Legal First Name: _____ MI: _____

Preferred Name: _____ Pronouns: _____

Other Names you may have used: _____

Social Security Number: _____ Date of Birth: _____

Address (Mailing): _____ City: _____ Zip Code: _____

Telephone: _____ May we contact you at home? Yes No

Other Contact: Cell Phone Work Phone Message Phone _____

Legal Sex: Male Female X

Gender: Male Female Trans Male Trans Female Other Nonbinary / Genderqueer
 Questioning Choose not to disclose

Ethnicity: Mexican Mexican American Chicano/a Puerto Rican Cuban
 Another Latino/a and/or Spanish Origin Non-Hispanic or Latino/a Unknown

Race: White Asian Indian American Indian African American Chinese Alaskan Native Filipino
 Japanese Korean Vietnamese Other Asian Other Pacific Islander Guamanian or Chamorro
 Samoan Native Hawaiian Unknown

Preferred Communication: No preference Mail Phone MyChart

Veteran Status: Yes No

Emergency Contact Information (for patient, or for responsible party if patient is a minor):

Emergency Contact Name: _____ Phone #: _____

Relationship to Patient: Spouse Mother Father Grandparent Other: _____

Are Interpreter Services Needed? Yes No

Primary Language: English Spanish Hmong Other: _____

Mother's Maiden Name: _____

Guarantor Information (The person responsible for payment, example: a parent for a patient under 18 years of age)

Last Name: _____ First Name: _____ MI: _____

Billing Address: same as above _____ City/Zip: _____

Relationship to Patient: Self Parent Other: _____

Social Security Number: _____ Legal Sex: Male Female X

Date of Birth: _____ Telephone: _____

Insurance Name: _____

Insurance ID Number: _____ Issue Date: _____

Where do you currently live?: In my home or apartment At a shelter Staying with others
 In transitional housing The street, a camp, under a bridge, or in a car

Migrant Status: Migrant Seasonal Neither

Office Use Only: Entered by: _____ Date: _____ MRN#: _____

Housing and Income Information

Sliding Fee Discount Program



Why we ask for this information

Open Door Community Health Centers receive grants and federal funding to support our services. Each year we must collect information about the communities we serve to share with our funders. By completing this form, you are helping us keep our funding so we can offer more services.

We combine your information with others and report it in summary form. We do not share any personal information or report data that could be used to identify you.

1. Information about you and where you live

Name	Birth date	MRN Office Use

Are you a veteran? (Check one) Yes No

How do you describe where you live? (Check one)

- Live in a place I own or rent (house, apartment, condo, or townhouse)
- Live in someone else's place on a temporary basis ("couch surfing")
- Live in transitional housing (Arcata House or halfway house)
- Live somewhere as part of a program or treatment (hospital, hotel or motel, respite care, treatment program, jail)
- Live in emergency shelter
- Live unsheltered (in a tent, car, around buildings or bridges)

At any time in the last 12 months were you without a regular place to live? (Check one) Yes No

2. Information about the people in your household

Please list the names and birth dates of the people in your household. Your household includes people you live and share an income with.

Name	Birth date	MRN Office Use

3. Information about household income

What is your household income before taxes or deductions? This is the total amount earned by all members of your household, including you.

Examples of income (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Wages or salary from employment or self-employment | <input type="checkbox"/> Alimony |
| <input type="checkbox"/> Other earnings from employment, such as tips or commissions | <input type="checkbox"/> Pension or Retirement income |
| <input type="checkbox"/> Child Support | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> Spousal Support | <input type="checkbox"/> Disability payments |
| <input type="checkbox"/> Any other source of income _____ | <input type="checkbox"/> Unemployment payments |

Total household income: \$ _____

Is this income (Check one) Weekly Monthly Annually

4. Eligibility for sliding fee discount scale co-payment

Based on your household income reported above you may be eligible for a discount on the fees for your services.

If you are reporting no income above, you must describe your current means of support and/or living situation:

We reserve the right to request evidence of your income in the form of pay stubs, tax returns, or other documents in order to qualify for discounts.

5. Certification and signature

I declare that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

Signature: _____ Date: _____

OFFICE USE ONLY SITE _____ Calculated Annual Income _____

Income Verified*: Yes (Expires 365 days) No ($\leq 200\%$ FPL-Expires 30days) No ($> 200\%$ FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: Yes

This applicant is: Eligible for Discount of: A Scale B Scale C Scale D Scale \$0 Co-pay**
 Not Eligible for Sliding Scale Discount Patient Declined

**\$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date: _____ Certified by: Signature: _____ Date: _____

Document eligibility for each family member for each account type within registration.

Enter date eligibility begins (the certification date on this sheet) for each eligible account.

Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for $SFS \leq 200\%$ and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)

Open Door's Member Services Referral Form

ASSISTANCE IS FREE!

Humboldt:

Phone: (707) 269-7073

Fax: (707)269-7045

Del Norte:

Phone: (707) 465-1988

Fax: (707) 465-1987

Member Services can help with:

- Applications for Health Care Benefits or Coverage
- Food resource assistance
- Health care access questions
- *And More!*

Name

Date of Birth:

Name of Parent/Guardian (if applicable)

Daytime Phone:

Email:

Address:

- Referred From:
- Mobile Dental
 - Open Door site:
 - Other:



Furgoneta dental móvil para niños

Cómo funciona

1. Complete los formularios **EN SU TOTALIDAD. UTILICE TINTA ÚNICAMENTE.** Devuélvalo a la escuela de su hijo/a.
2. Si no necesita estar presente, retiraremos a su hijo/a de la clase para completar un examen dental con radiografías. Si desea estar presente, nos comunicaremos con usted para programar una cita.
3. Se enviará a su casa una carta en la que se detallarán los resultados del examen de su hijo/a y el tratamiento necesario.
4. El tratamiento se completará durante el horario escolar.
5. En 6 meses, llame a la Burre o Fortuna Dental Clinic para el próximo control de su hijo/a.



Nuestros servicios

- Examen integral
- Limpiezas
- Selladores
- Empastes blancos
- Coronas de acero inoxidable
- Extracciones
- Educación sobre la salud bucal

opendoor
Community Health Centers

Póngase en contacto con nosotros al
: (707) 407-7713

Aceptamos Meds-Cal/Partnership, todos los seguros privados y trabajamos con personas sin seguro. No se negará atención a ningún niño o niña por falta de capacidad de pago.

Consentimiento para el tratamiento, el pago y la divulgación de información

Nombre del niño/niña en letra de imprenta

Fecha de nacimiento del niño/niña

¿Qué atención dental desea que reciba su hijo/a?

Marque la casilla junto a cada servicio que desee para su hijo/a.

- Examen dental:** incluye radiografías dentales.
- Servicios preventivos:** incluye limpieza, tratamiento con flúor, selladores y educación sobre la salud bucal.
- Tratamiento de caries:** incluye empastes, coronas, tratamientos de la pulpa/el nervio. *Es posible que se utilice anestesia.*
- Extracción de diente de leche:** *es posible que se utilice anestesia.* Si es necesario, es posible que se administre una dosis de ibuprofeno para niños. Llamamos el día anterior para informarle.

Nota: La extracción de un diente permanente requiere un consentimiento adicional.

¿En qué citas le gustaría estar presente? Se llevará a cabo en horario escolar. Tenga en cuenta que el espacio en la furgoneta es limitado y es posible que tenga que esperar afuera a una distancia corta.

Marque la casilla junto a cada servicio en el que le gustaría estar presente.

- NO necesito estar presente para las citas.
- Quiero estar presente durante el examen.
- Quiero estar presente para los servicios preventivos (limpiezas y selladores).
- Quiero estar presente durante los empastes.
- Quiero estar presente durante las extracciones.

Pago

Si mi hijo/a tiene seguro dental o Medi-Cal/Partnership, acepto presentar su tarjeta de cobertura actual. No se negará atención a ningún niño o niña, independientemente de su capacidad de pago.

Consentimientos adicionales Utilice el código QR para acceder.

También disponible en <https://opendoorhealth.com/locations/burre-dental-center/mobile-dental-van/>

Estoy de acuerdo en que los siguientes consentimientos se pusieron a mi disposición para que los revise y estoy de acuerdo con los términos incluidos en estos documentos.

- Aviso de prácticas de privacidad de Open Doors
- Hoja informativa de material dental
- No puedo acceder a los formularios electrónicamente y solicito una copia impresa.



Al firmar a continuación, acepto lo siguiente:

- He leído este consentimiento o me han leído este consentimiento.
- Entiendo las declaraciones anteriores y doy mi consentimiento con respecto a ellas.
- Autorizo al personal del Programa dental móvil de Open Door a brindar la atención dental que elegí anteriormente.
- Según mi leal saber y entender, la información que proporcioné anteriormente es verdadera y correcta.
- He tenido la oportunidad de leer la Hoja informativa de material dental y el Aviso de prácticas de privacidad de Open Door.

Nombre en letra de imprenta del adulto que da su consentimiento

Firma del adulto que da su consentimiento

Fecha

Relación del adulto con el niño/la niña

Número de teléfono diurno

Llamada
Mensaje de texto
Preferencia
Escoge uno

Open Door Community Health Centers
Antecedentes de salud dental móviles

Nombre completo del niño/niña: Nombre: _____ Apellido: _____ Fecha de nacimiento: _____

Edad: _____ Nombre completo del padre/madre/tutor: Nombre: _____ Apellido: _____

ANTECEDENTES MÉDICOS

NHC del niño/niña: _____

Fecha del último examen médico: _____ Nombre del proveedor: _____ Especialistas: _____

¿Su hijo/a ha tenido alguna de las siguientes afecciones?

	SÍ	NO		SÍ	NO
Latidos cardíacos irregulares o presión arterial	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (nivel alto o bajo de azúcar en sangre)	<input type="checkbox"/>	<input type="checkbox"/>
Defecto cardíaco congénito o cirugía cardíaca	<input type="checkbox"/>	<input type="checkbox"/>	Tratamiento del comportamiento o psiquiátrico	<input type="checkbox"/>	<input type="checkbox"/>
Válvula cardíaca artificial	<input type="checkbox"/>	<input type="checkbox"/>	TDA/TDAH	<input type="checkbox"/>	<input type="checkbox"/>
Trastornos sanguíneos (anemia, anemia falciforme)	<input type="checkbox"/>	<input type="checkbox"/>	Trastorno del espectro autista	<input type="checkbox"/>	<input type="checkbox"/>
Hemofilia o sangrado excesivo	<input type="checkbox"/>	<input type="checkbox"/>	Discapacidad intelectual o del desarrollo	<input type="checkbox"/>	<input type="checkbox"/>
Cáncer/radiación/quimioterapia	<input type="checkbox"/>	<input type="checkbox"/>	Deterioro de la visión, la audición o el habla	<input type="checkbox"/>	<input type="checkbox"/>
Problemas hepáticos o renales	<input type="checkbox"/>	<input type="checkbox"/>	Infecciones frecuentes de los senos paranasales o las amígdalas	<input type="checkbox"/>	<input type="checkbox"/>
Enfermedad de la tiroides	<input type="checkbox"/>	<input type="checkbox"/>	Asma o problemas respiratorios	<input type="checkbox"/>	<input type="checkbox"/>
Convulsiones/epilepsia	<input type="checkbox"/>	<input type="checkbox"/>			

¿Alguna vez tuvieron que hospitalizar a su hijo/a? En caso afirmativo, ¿para qué?

¿Tuvo algún otro problema o afección que no esté en la lista?

MEDICAMENTOS (incluye medicamentos recetados, medicamentos de venta libre e inhaladores)

Marque aquí si no toma ninguno (use la parte de atrás si necesita más espacio)

ALERGIAS

Marque aquí si no tiene ninguna

Fecha del último examen dental: _____ Dentista/clínica: _____

- ¿Un adulto ayuda con el cepillado y el uso del hilo dental? Sí/No
- ¿Ha tenido el niño/la niña alguna experiencia desagradable en el consultorio dental o médico? Sí/No
- ¿El niño/la niña ha tenido alguna lesión en la cara, la boca o los dientes? Sí/No
- ¿Tiene el niño/la niña algún hábito oral (chuparse el dedo, morderse las uñas, etc.)? Sí/No
- ¿El niño/la niña se ha quejado de dolor de dientes? Sí/No

¿Tiene alguna pregunta o inquietud específica?

Por favor, notifíquenos si se producen cambios. Las citas pueden reprogramarse si el niño/la niña está enfermo/a o tiene dificultades para respirar por la nariz.

Firma del padre/madre/tutor: _____ **Fecha:** _____

Apellido Legal: _____ Primer Nombre Legal: _____ MI: _____

Nombre Preferido: _____ Pronombres: _____

Otros nombres que ha usado: _____

Número de Seguro Social: _____ Fecha de nacimiento: _____

Dirección (para correo): _____ Ciudad: _____ Código Postal: _____

Número de teléfono: _____ ¿Podemos contactarle en casa? Sí No

Otro método de contacto: Teléfono móvil teléfono del trabajo Teléfono para mensajes _____

Sexo Legal: Masculino Femenino X

Género: Masculino Femenino Transgénero – Masculino; Femenino a Masculino Transgénero –

Femenino; Masculino a Femenino Otra No binario /Género Queer Indeciso Prefiero no decir

Origen Étnico: Hispano No Hispano No se

Raza: Blanco Asiático Americano Nativo Afroamericano De las Islas del Pacífico Nativo de Alaska

No se sabe

Forma de comunicación preferida: No tengo preferencia Correo Teléfono MyChart

¿Es Veterano militar? Sí No

Contactos en caso de emergencia (para el paciente, o para el padre/guardián si el paciente es menor de edad)

Nombre de contacto en caso de emergencia: _____ Teléfono: _____

Relación con el paciente: Esposa/o Mamá Papá Abuelos Otro: _____

¿Necesita servicios de interpretación? Sí No

Su Lenguaje: Inglés Español Hmong Otro: _____

Apellido de soltero de la mama: _____

Información del fiador (La persona que paga los cobros, por ejemplo: El padre de un paciente menor de edad.)

Apellido: _____ Primer Nombre: _____ MI: _____

Dirección: La misma descrita arriba _____ Ciudad/Código Postal: _____

Relación al paciente: Mismo Papá/Mamá Otro: _____

Número de Seguro Social: _____ Sexo Legal: Masculino Femenino X

Fecha de nacimiento: _____ Teléfono: _____

Nombre del seguro médico: _____

Numero de ID del seguro médico: _____ Fecha de emisión: _____

Situación de vivienda: Ahora tengo hogar Vivo en un refugio Vivo con otras personas Hogar temporal

Vivo en la calle, campamento, puente

Estatus migratorio: Inmigrante Trabajador temporal Ninguno de esos

Office Use Only: Entered by: _____ Date: _____ MRN#: _____

Información de Vivienda e Ingreso

Programa de descuento de tarifa variable



¿Por qué pedimos esta información?

Los Centros de Salud Comunitarios Open Door reciben subsidios y fondos federales para apoyar nuestros servicios. Cada año debemos recopilar información sobre las comunidades que servimos para compartir con nuestros financiadores. Al completar este formulario, nos está ayudando a mantener nuestros fondos para que podamos ofrecer más servicios.

Combinamos su información con otras y la informamos en forma resumida. No compartimos ninguna información personal ni informamos datos que puedan usarse para identificarlo.

1. Información sobre usted y dónde vive

Nombre	Fecha de nacimiento	Uso de MRN Office

¿Es usted un veterano? (Marque uno) Sí No

¿Cómo describe el lugar dónde vive? (Marque uno)

- Vive en su propia casa o renta (casa, apartamento o condominio)
- Vive con otra persona de forma temporal ("por ejemplo, durmiendo en el sofá en la casa de otra persona")
- Vive en una vivienda de transición (Casa Arcata u otra casa de transición)
- Vive en algún lugar como parte de un programa o tratamiento (hospital, hotel o motel, cuidado de relevo, programa de tratamiento, cárcel)
- Vive en un refugio de emergencia
- Vive desprotegido (en una tienda de campaña, automóvil, alrededor de edificios o puentes)

¿En algún momento de los últimos 12 meses estaba sin un lugar regular para vivir?

(Marque uno) Sí No

2. Información sobre las personas en su hogar

Por favor, enumere los nombres y fechas de nacimiento de las personas en su hogar. Su hogar incluye a las personas con las que vive y con las que comparte un ingreso.

Nombre	Fecha de nacimiento	Uso de MRN Office

3. Información sobre los ingresos del hogar

¿Cuál es el ingreso de su hogar antes de impuestos o deducciones? Esta es la cantidad total ganada por todos los miembros de su hogar, incluyéndolo a usted.

Ejemplos de ingresos (marque todos los que correspondan):

- | | |
|---|---|
| <input type="checkbox"/> Salarios o salarios del empleo o del trabajo por cuenta propia | <input type="checkbox"/> Pensión alimenticia |
| <input type="checkbox"/> Otras ganancias del empleo, como propinas o comisiones | <input type="checkbox"/> Pensión o ingresos de jubilación |
| <input type="checkbox"/> Manutención de los hijos | <input type="checkbox"/> Seguridad social |
| <input type="checkbox"/> Manutención conyugal | <input type="checkbox"/> Pagos por discapacidad |
| <input type="checkbox"/> Cualquier otra fuente de ingreso _____ | <input type="checkbox"/> Pagos por desempleo |

Ingreso total del hogar: \$ _____

¿Es este ingreso? (Cheque uno) Semanal Mensual Anual

4. Elegibilidad para el copago de la escala de descuento de tarifas proporcionales

Según los ingresos de su hogar informados anteriormente, puede ser elegible para un descuento en las tarifas de sus servicios.

Si no reporta ningún ingreso arriba, debe describir su medio actual de manutención y / o situación de vida:

Nos reservamos el derecho de solicitar evidencia de sus ingresos en forma de talones de pago, declaraciones de impuestos u otros documentos para calificar para descuentos.

5. Certificación y firma

Declaro que la información que he dado en este formulario es verdadera, correcta y completa. Entiendo que la entrega de información falsa puede hacerme inelegible para servicios con descuento.

Firma _____ Fecha: _____

OFFICE USE ONLY	SITE _____	Calculated Annual Income _____
Income Verified*: <input type="checkbox"/> Yes (Expires 365 days) <input type="checkbox"/> No ($\leq 200\%$ FPL-Expires 30days) <input type="checkbox"/> No ($> 200\%$ FPL- Expires 365days)		
Notified Patient about eligibility screening and application assistance through Open Door Member Services: <input type="checkbox"/> Yes		
This applicant is: <input type="checkbox"/> Eligible for Discount of: <input type="checkbox"/> A Scale <input type="checkbox"/> B Scale <input type="checkbox"/> C Scale <input type="checkbox"/> D Scale <input type="checkbox"/> \$0 Co-pay** <input type="checkbox"/> Not Eligible for Sliding Scale Discount <input type="checkbox"/> Patient Declined		
**\$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.		
Termination date: _____ Certified by: Signature: _____ Date: _____		
Document eligibility for each family member for each account type within registration. Enter date eligibility begins (the certification date on this sheet) for each eligible account. Scan form into Documents under FDS – Financial Document, DESC – FPL.		
*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS $\leq 200\%$ and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)		

Open Door's Servicios para Miembros Formulario

¡ASISTENCIA ES GRATIS!

Humboldt:
Teléfono: (707) 269-7073
Fax: (707)269-7045

Del Norte:
Teléfono: (707) 465-1988
Fax: (707) 465-1987

Nuestro Servicios para Miembros les puede ayudar con:

- *Aplicaciones para cobertura o beneficios de cuidado de salud*
- *Asistencia recursos alimenticos*
- *Preguntas sobre acceso al cuidado de la salud*
- *¡Y Más!*

Nombre

Fecha de Nacimiento:

Nombre del padre o guardián (si es aplicable):

Número de teléfono durante el día:

Email:

Dirección:

Referred From/
Derivados

- Mobile Dental
 Open Door site:
 Other:

Upcoming 2025 Pathway to Payday Events

Pathway to Payday is a FREE 4-day employment workshop series for community members that focuses on enhancement of application, resume and interview skills, and offers participants the opportunity to interview with real employers for real jobs.

Events take place 9am-12pm each day at the Betty Chinn Day Center. Find out more and apply at uplifteureka.com/pathway, or call 707-672-2253.

1 February 10th-13th

May 5th - 8th

2

3 July 28th - 31st

November 3rd-6th

4

PREPARATORY WORKSHOPS

FEBRUARY 3/4TH

APRIL 28/29TH

JULY 21ST/22ND

OCTOBER 27/28TH

Schedule a time to work with Uplift staff to create or polish your resume, sign up for the businesses you'd like to interview with, and complete applications in preparation for your interviews.

APPLYING FOR THE JOB YOU WANT

DAY
1

Learn how to best represent your work history & skill set, find out how to avoid common application mistakes, & discover what today's employers are looking for.

MOCK INTERVIEWS

DAY
2

Gain valuable interview skills by engaging in interactive mock interviews that will allow you to test your interview skills & receive valuable feedback to prepare for real interviews!

REAL INTERVIEWS

DAY
3

Put your skills into action when you interview with real employers for real jobs. Participants are not guaranteed a job, but are guaranteed this opportunity... so make the most of it!

THE NEXT STEPS

DAY
4

In the final workshop, receive feedback from your job interviews, and leave with tools to set you up for success in a new job.

SEAN'S SHADOWS

Family Literacy Party

The Cat Drum:
How the cat got its purr!

A FREE event for kids and the adults who love them. Each attendee gets to choose a free book to keep!



Saturday, March 1



Arcata Library at 11 a.m.
500 7th St, Arcata



Blue Lake Library at 2 p.m.
111 Greenwood Ave, Blue Lake

Artist, musician, and storyteller Sean Powers presents tales of folklore and fantasy using handcrafted shadow puppets and musical instruments from around the world.

The Cat Drum is based on a Caribbean story about how the cat got its purr.

Info: www.humlib.org
(707) 269-1910

Since 1981, Humboldt Literacy Project has provided free, confidential English Language tutoring with programs for native English speakers, English as a second language, and family literacy. (707) 445-3655



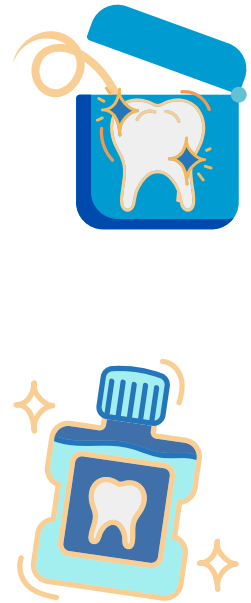
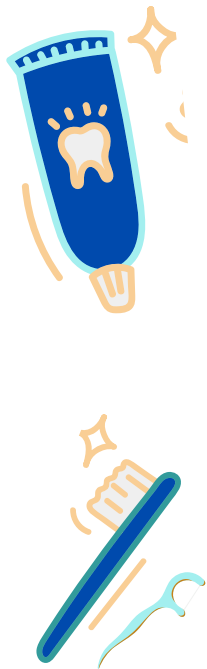
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Humboldt
Literacy
Project



HUMBOLDT COUNTY
Library

YOU CAN BE A TOOTH FAIRY TO LOCAL FAMILIES IN NEED BY DONATING DENTAL SUPPLIES FEBRUARY - MARCH 2025



HELP US BREAK LAST YEAR'S RECORD COLLECTION OF 3,000+ DENTAL ITEMS!

Humboldt County's First Annual Smile Drive in 2024 collected more dental care items than any other drive held across the country. Donated toothbrushes, floss/flossers and toothpaste are provided to local schools, Family and Community Resource Centers and other social support organizations providing services to children and adults who have limited access to supplies.

You can donate in the following ways:

- Shop our Amazon Smile Drive Wish List
- Make an online contribution (\$1 = 1 toothbrush)
- Collect and take items to a drop-off location
- Buy and donate supplies at Eureka Grocery Outlet.



If interested in supporting Humboldt County's Smile Drive, please scan the QR code or visit: smilehumboldt.com/SmileDrive2025.



FREE TAX PREPARATION!

The Volunteer Income Tax Assistance Program – VITA provides FREE tax preparation whose combined household income was less than \$79,000 in the 2024 tax year.



Earn It!
Keep It!
Save It!

THE EARN IT, KEEP IT, SAVE IT PROGRAM OFFERS:

- FREE Tax Preparation by IRS Certified Preparers
- Tax credit assistance with Earn Income Tax Credits, Child or Dependent Care Credits and Education Credit

Call for drop off locations and times or to book an appointment
707-572-5045





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Triple P

Positive Parenting Series

Free classes for caregivers of children 0-12 years old.
In each session we will discuss positive parenting strategies.

SESSION 1: THE POWER OF POSITIVE
PARENTING

THURSDAY, FEBRUARY 20TH

SESSION 2: RAISING CONFIDENT,
COMPETENT CHILDREN

THURSDAY, FEBRUARY 27TH

SESSION 3: RAISING RESILIENT CHILDREN

Thursday, March 6th

This parenting support series
is approved by the COURTS
and Social Services Family
Plans

Certificates
and gift cards!



Scan here to register
or contact Karina 707-506-6202

4:30-6 pm

On Zoom



@first5humboldt

TRIPLE P POSITIVE PARENTING SERIES



**FREE
Childcare
& Food!**

Free classes for caregivers of children 0-12 years old. Explore ways to build positive, healthy relationships.

Series Sessions:

- ✓ **Session 1 (3/11):** The Power of Positive Parenting
- ✓ **Session 2 (3/18):** Raising Confident, Competent Children
- ✓ **Session 3 (3/25):** Raising Resilient Children
- ✓ **Session 4 (4/1):** Safety Preparedness at Home
*Potluck dinner night!

**Tuesdays, Mar. 11 - Apr. 1
5:30-7:00 PM
Blue Lake Union ESD
Cafeteria**

Book Now!



tinyurl.com/PPPParenting



For More Info:

Karina (707)506-6202



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HUMBOLDT**

