Gunalchéesh/Haw'aa for your interest in Head Start!

Head Start Application 2021/22

INSTRUCTIONS

1. *To Apply—there are 2 options*
    a. *By Paper. Print/Save, fill out, & email to headstartenrollment@ccthita-nsn.gov*
    b. *Online. Fill out the following pages, digitally sign, & click submit*

2. *Send Income Verification—with your paper application or separately if you submitted your application online.*
    a. *At least one of the following documents are required per working adult(s) in the home:*
        i. *Income Documentation—for last 30-days, i.e. check stubs, or*
        ii. *Latest Income Tax Form—i.e. W-2 or 1040, or*
        iii. *Proof of Unemployment Insurance, or*
        iv. *Proof of Public Assistance—i.e. TANF/ATAP, SSI, or*
        v. *Homeless Documentation-i.e. written statement from homeless service provider, documentation from pubic or private agency, a declaration, information gathered on application, notes from an interview, or*
        vi. *Send Foster Care Verification-court order, or other legal or govenment-issued document, or foster care payment.*

3. *Send Immunization Records*

4. *Send Child's TB Risk assessment*

5. *Send IEP/IFSP document(s), if applicable*

INSTRUCTIONS TO SUBMIT

(4) different ways

In-Person. 9095 Glacier Highway, Juneau, AK 99801, or
By Mail. 9097 Glacier Highway, Juneau, AK 99801, or
Phone. 1.800.344.1432, or
Fax. 1.877.389.7796, or
Email. headstartenrollment@ccthita-nsn.gov

This institution is an equal opportunity provider.

Revised 02.2021

Tlingit & Haida Head Start

Physical Address:
9095 Glacier Highway
Juneau, AK 99801
Phone: (907)463-7127

Mailing Address:
9097Glacier Highway
Juneau, AK 99801
Fax: (877) 389-7796

Program Year 2021/22

SECTION A CHILD INFORMATION

FULL FIRST NAME:	FULL MIDDLE NAME:	FULL LAST NAME:	SUFFIX:

NICKNAME:	DOB:	☐ MALE ☐ FEMALE

RACE: *(Choose all that apply)*
- ☐ Alaska Native
- ☐ American Indian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Asian
- ☐ Pacific Islander/Native Hawaiian

ETHNICITY: *(Choose one)*
- ☐ Hispanic
- ☐ Non-Hispanic

CHILD PRIMARY LANGUAGE: _____
- ☐ Little
- ☐ Moderate
- ☐ Proficient

CHILD SECONDARY LANGUAGE: _____
- ☐ Little
- ☐ Moderate
- ☐ Proficient

SECTION B PRIMARY ADULT

FIRST NAME:	LAST NAME:	DOB:	☐ MALE ☐ FEMALE

PRIMARY LANGUAGE:

Translation or Interpretation Services Needed ☐ Yes ☐ No

RACE: *(Choose all that apply)*
- ☐ Alaska Native
- ☐ American Indian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Asian
- ☐ Pacific Islander/Native Hawaiian

ETHNICITY: *(Choose one)* ☐ Hispanic ☐ Non-Hispanic

MILITARY STATUS: ☐ Active ☐ Veteran

PRIMARY PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

ALTERNATE PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

E-MAIL:

RELATIONSHIP TO CHILD: *(Check one)*
- ☐ Parent/Legal Guardian
- ☐ Grandparent
- ☐ Legal Foster Parent *(Attach letter)*
- ☐ Other:_____

HIGHEST EDUCATION LEVEL: *(Check one)*
- ☐ Highest Grade:_____
- ☐ High School Graduate
- ☐ GED
- ☐ COL
- ☐ AA
- ☐ BA
- ☐ MA or Higher

EMPLOYMENT STATUS: *(Check one)*
- ☐ FT only
- ☐ PT only
- ☐ Seasonal
- ☐ Training/School
- ☐ FT and School
- ☐ PT and School
- ☐ Retired or Disabled
- ☐ Unemployed

SECTION C SECONDARY ADULT

FIRST NAME:	LAST NAME:	DOB:	☐ MALE ☐ FEMALE

PRIMARY LANGUAGE:

Translation or Interpretation Services Needed ☐ Yes ☐ No

RACE: *(Choose all that apply)*
- ☐ Alaska Native
- ☐ American Indian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Asian
- ☐ Pacific Islander/Native Hawaiian

ETHNICITY: *(Choose one)* ☐ Hispanic ☐ Non-Hispanic

MILITARY STATUS: ☐ Active ☐ Veteran

PRIMARY PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

ALTERNATE PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

E-MAIL:

RELATIONSHIP TO CHILD: *(Check one)*
- ☐ Parent/Legal Guardian
- ☐ Grandparent
- ☐ Legal Foster Parent *(Attach letter)*
- ☐ Other:_____

HIGHEST EDUCATION LEVEL: *(Check one)*
- ☐ Highest Grade:_____
- ☐ High School Graduate
- ☐ GED
- ☐ COL
- ☐ AA
- ☐ BA
- ☐ MA or Higher

EMPLOYMENT STATUS: *(Check one)*
- ☐ FT only
- ☐ PT only
- ☐ Seasonal
- ☐ Training/School
- ☐ FT and School
- ☐ PT and School
- ☐ Retired or Disabled
- ☐ Unemployed

Secondary Adult Lives with Primary Parent: ☐ Yes ☐ No*

*If NO, is there a Custody Agreement? ☐ Yes *(Attach documentation)* ☐ No

USDA and this institution are equal opportunity providers and employers. Parent/Guardians have the right to receive translation or interpretation services in their primary language as well as reasonable accommodations to participate in the program.

SECTION D FAMILY INFORMATION

LIVING ADDRESS:

Address:_____

City:_____, AK Zip _____

MAILING ADDRESS:

Address:_____

City:_____, AK Zip _____

HOUSING: *(Check one)*
- ☐ Own
- ☐ Rent
- ☐ Neither

PARENTAL STATUS: *(Check one)*
- ☐ One Parent
- ☐ Two Parent
- ☐ Teen Parent *(age 19 or under at time of birth)*

Do you live in a shelter, transitional housing, motel, vehicle or move frequently between homes of relatives or friends? *(Attach housing verification)*

☐ Yes ☐ No

Was your family referred for services by a child welfare agency? *(Office of Children's Services, Child in Transition, ICWA, etc.)*

☐ Yes ☐ No

SERVICES YOUR FAMILY RECEIVES: *(Check all that apply)*
- ☐ None
- ☐ Child Care Assistance
- ☐ SNAP/Food Stamps
- ☐ WIC
- ☐ Indian Health Services (IHS)
- ☐ TANF/ATAP
- ☐ Supplemental Security Income

Number of individuals related by blood, marriage or adoption, living in the home, supported by the **parent/guardian's** income:

NUMBER OF ADULTS: _____ **NUMBER OF CHILDREN:** _____ **TOTAL NUMBER:**_____

Please list **all** members of the household. If more than one child is applying for HS, an application is needed for each child.

First	Middle Initial	Last	Relation to HS Applicant	Birthday	Gender	Race	Hispanic/ Latino
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No

SECTION E CHILD HEALTH INFORMATION

PRIMARY HEALTH COVERAGE/INSURANCE:
- ☐ Denali KidCare/Medicaid
- ☐ Private
- ☐ Other: _____
- ☐ None

DOCTOR/MEDICAL CLINIC NAME:

PHONE:

DENTIST/DENTAL CLINIC NAME:

PHONE:

Does your child have any diagnosed food or medical allergies?
☐ Yes* ☐ No If YES, please explain:

**If your child has a food allergy, a completed "Medical Statement for Food Substitution" or other documentation MUST be provided before food substitutions can be made.*

Does your child take any medications that have to be administered during class time? *(Head Start Only)* ☐ Yes* ☐ No

**If YES, parent/guardian will be required to fill out a separate medication authorization form prior to the first day of attendance.*

Do you have any health concerns about your child?
☐ Yes ☐ No If YES, please explain:

Do you have any developmental concerns about your child?
☐ Yes ☐ No If YES, please explain:

SECTION F CHILD INDIVIDUALIZED EDUCATION PLAN (IEP)/ INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

Is your child currently being evaluated for an IEP or IFSP?

☐ Yes ☐ No ☐ Suspected

Does your child have a current or expired IEP or IFSP?
☐ Yes ☐ No If YES, please attach copies of the:

☐ IEP **or** ☐ IFSP **or** ☐ Signed Release of Information Form

AGREEMENT PLEASE READ, SIGN, AND DATE YOUR APPLICATION

I certify that this information is true and correct. I agree to promptly update my child and family's information during my child's enrollment with Tlingit & Haida Head Start. I agree to review this information every year. All information is kept strictly confidential and I may access it during normal business hours.

PARENT/GUARDIAN SIGNATURE:

DATE:

Tlingit & Haida Head Start

ERSEA (Enrollment)

REQUEST TO RELEASE & EXCHANGE INFORMATION AND NOTICE OF CONFIDENTIALITY

Dear Parent/Guardians:

In order to provide your family with quality services, it may be necessary to release and exchange information with others that serve your family and child. For example, to review your Head Start eligibility, we need income statements from **ATAP** or **TANF**. Other examples are to allow us to send forward immunization records to your local school when transition to kindergarten, or requesting current immunization records, physical or dental exam from your health care providers. We need your written consent to legally release and exchange information. This Request to Release to Exchange information form allows us to share this information between programs/agencies.

All the information gather about your family is kept confidential and released only when you give us permission. Parents and legal guardians of Head Start children have the right to access their own children's files at the Head Start center as well as at the Head Start Central Office located in Juneau, Alaska.

Child Name:	**Date of Birth:**

To rush your application pleases provide:

Alaska Temporary Assistance Program (**ATAP**) Benefits-Case worker: _____

Temporary Assistance for Needy Families (**TANF**) Case worker: _____

Supplemental Security Insurance (**SSI**) Benefits-Case#: _____

State Disabilities Assistance Benefits-Case#: _____

Foster Care-Health & Social Services: _____

Guardianship – Alaska Legal Services: _____

****

****SEARHC** requires a specific **Release of Information form** to release & exchange information to Head Start**. If you are a SEARHC client, please complete a Head Start & SEARHC form in addition to this ROI form. ****

I request the following information for me or my child to be released and exchanged between Tlingit & Haida Head Start…

Check the following and provide clinic names (required):

- ☐ **Dental Records/Name of Clinic: _____**
- ☐ **Medical Records/Name of Clinic: _____**
- ☐ **Immunization & TB test records/Name of Clinic: _____**

Check the following if you receive these services for your child and name of agency (required):

- ☐ **Infant Learning Program (ILP)/or other program: _____**
- ☐ **Developmental screening and assessment information at: _____**
- ☐ **Individualized Education Plan (IEP or IFSP) from Local Education Agency (LEA): _____**
- ☐ **Behavioral or Social/Emotional Service Agency: _____**
- ☐ **Individual Learning Plan (ILP) records from another Pre-K Program: _____**
- ☐ **Other (records created during Child find, Tots Clinic, etc.): _____**

THIS RELEASE & EXCHANGE OF INFORMATION IS VALID FOR 12 MONTHS FROM DATE SIGNED.

_____ _____ _____

Parent/Guardian Signature **Printed Name** **Date**

SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH

This form is for release of information requests to third parties. Please allow up to 30 days for SEARHC to process your request. Incomplete forms will be returned. There may be a fee associated with processing the request. Staff will inform you if the fee applies.

Printed Name of Patient:	Previous Names (if applicable):
Date of Birth (MM/DD/YYYY):	Daytime Telephone Number:

INFORMATION TO BE RELEASED FROM:	**SEND INFORMATION TO:**
Provider Name/Organization: **SEARHC**	Name of Person/Facility/Organization: **Central Council Tlingit and Haida Indian Tribes of Alaska- Head Start**
Address: 3100 Channel Drive Ste. 300 Juneau, AK 99801	**Address:** 9095 Glacier Hwy Juneau, AK 99801
Contact Number: 907-463-6630	**Contact Number:** 1.800.344.1432/x7153
Fax Number: 907-463-4012	**Fax Number:** **1.877.389.7796**
Format in which you would like the recipient to receive your records: ____Mail __**X**__ Fax __Pick Up ____Verbal ____ Encrypted Email ____ Unencrypted email (there is a risk that your records may be intercepted or viewed if sent unencrypted.) Email address: _____	

REQUIRED INFORMATION

PURPOSE OF DISCLOSURE:

____ Transfer of Care ____ Disability ____ Law Enforcement ____ Specialist
____ Attorney __**X**__ Head Start School ____ Insurance ____ Other: _____

INFORMATION TO BE DISCLOSED:

____ Medical records from the last two years ____ Complete Designated Record Set
Date(s) of Service: ____/____/____ through ____/____/____

___ Health Summary ____ Billing records ____ Emergency room records
____ Discharge summary ____ Physician progress notes ____ Nursing notes
____ Laboratory/pathology reports ____ Radiology reports ____ Radiology images
____ Medication list __**X**__ Immunization record ____ Accounting of disclosures
____ Dental chart note ____ Dental Pano X-ray ____ Dental X-ray
__**X**__ Other: ***Head Start Physical Exam Form*** (*Including: Grow measurement, Blood Pressure, Vision, Hearing, TB, Hemoglobin/Hematocrit, Physical/Developmental Assessment, allergies and chronic illness*), & **Head Start Dental Exam Form** (*Including: Procedures Performed, Caries Risk Status, Current Oral Health Status, Recommendations, & Treatment Plan*)
_____

Disclosures Requiring Special Consent:
If your records contain any of the information listed below, please initial next to that information to indicate that we are allowed to release these type of records:
____ HIV/AIDS Virus ____ Mental Health/Psychiatric Disorders ____ Sexually Transmitted Diseases
____ Substance Use/Treatment
This form may be revoked at any time by submitting a written request to the address below, provided the information has not already been disclosed. This authorization expires 90-days from date of signing unless an alternate expiration date or event is indicated (not to exceed one-year.)

Alternate expiration date/event: **1 Year from date of signature**

We will not condition or deny treatment on completion of this authorization. Please be aware that once we disclose this information, the information is subject to re-disclosure and may no longer be protected by HIPAA.

I have read and understand this form and authorize the information to be released as indicated.

_____	_____	_____
Signature of patient or personal representative*	Relationship to patient	Date

ID # _____

**legal documentation may be required to confirm the authority or the personal representative*.

SEARHC HIM DEPARTMENT
3100 Channel Dr., Suite 300
Juneau, AK 99801
P: 907-463-6630 F: 907-463-4012

For Facility Use:

Date Received:	Date Released:	MRN #:	Acct #:	ROI #:	Released by:

TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska

Mailing: 9097 Glacier Hwy, Juneau, AK 99801• Physical 9095 Glacier Highway • Juneau AK 99801
Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.ccthita-nsn.gov

Tuberculosis Risk Assessments Questionnaire

Date:

Dear Parent/Guardian:

Please complete this TB risk assessment regarding your Head Start student.

Child's Name		**Date of Birth**	
Head Start Center			
TB testing is required if any "YES" boxes are checked			
Close contact to someone with infectious TB during the student's lifetime • Re-testing should only be done in children who previously tested negative and have had no close contact with an infectious TB case since the last assessment.			□ Yes
Birth, travel or residence in a country with an elevated TB rate for at least 1 month • Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe			□ Yes
Immunosuppression, current or planned • HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids for more than 2 weeks (i.e., equivalent of prednisone ≥ 2 mg/kg/day, or ≥ 15mg/day for ≥ 2 weeks), or other immunosuppressive medication.			□ Yes
□ **None of the above apply**; TB testing is not required at this time.			
Please note: • Do not repeat TB testing unless there are *new* risk factors since the last negative test. • Children with a newly positive TB test result will be referred to their healthcare provider for a medical evaluation and parents/guardians will be notified.			
Parent/Guardian Signature			**Date**

This section to be filled out by Head Start Child Health & Safety Coordinator reviewing this assessment.		
Assessment Reviewed by		**Date**
Follow-Up, if needed	Due Date	Follow-Up completed? □ Yes □ No

Mail or fax a copy of physical & screenings to Head Start:
Attention*: Child Health & Safety Coordinator*

SUBMIT