Central Council Tlingit and Haida Indian Tribes of Alaska
TLINGIT & HAIDA HEAD START
Mailing Address: P.O. Box 25500 • Juneau, AK 99802
Physical Address: 9095 Glacier Highway • Juneau AK 99801
Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.ccthita-nsn.gov

2023-2024 Head Start Application Instructions

How to Apply:

- Apply Online: Complete the online application from Head Start's webpage (www.ccthita-nsn.gov/services/family/headstart), digitally sign, and submit.
- Email: Download a copy of the PDF application from Head Start's webpage (www.ccthita-nsn.gov/services/family/headstart), complete the application, and email to headstartenrollment@ccthita-nsn.gov.
- Printed Application: Print the PDF application or request an application to be mailed and return completed application to Head Start by mailing to PO Box 25500, Juneau, AK 99802.

Application Checklist:

☐	Head Start Application
☐	Income Verification - At least one of the following documents are required per working adult(s) in the home: • Income Documentation for Last 30 Days (i.e., check stubs) • Latest Income Tax Form (i.e., W-2 or 1040) • Proof of Unemployment Insurance or Proof of Public Assistance (i.e., TANF/ATAP, SSI or SNAP) • Proof of lack of fixed, regular, or adequate housing (i.e., written statement from service provider, documentation from public or private agency, a declaration, information gathered on application, notes from an interview) • Foster Care Verification court order, other legal or government-issued document, or foster care payment.
☐	Immunization Records
☐	Child's TB Risk Assessments Questionnaire
☐	IEP/IFSP document(s), if applicable

How to Submit Your Application:

- In-Person: 9095 Glacier Highway, Juneau, AK 99801
- By Mail: PO Box 25500, Juneau, AK, 99802
- Phone. 907.463.7127 or 1.800.344.1432
- Fax: 1.877.389.7796
- Email: headstartenrollment@ccthita-nsn.gov

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

This institution is an equal opportunity provider.

2023-2024 Tlingit & Haida Head Start Application

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: *(How many months working?)*
- ☐ 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: *(How many months working?)*
- ☐ 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 theirprimary 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)*
- ☐ Child Care Assistance
- ☐ SNAP/Food Stamps
- ☐ WIC
- ☐ Indian Health Services (IHS)
- ☐ TANF/ATAP
- ☐ Supplemental Security Income
- ☐ None

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 additional 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
							☐ 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:

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ERSEA (Enrollment)
Request to Release & Exchange Information and Notice of Confidentiality

Dear Parents/Guardians:

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 child's eligibility, Head Start will need income statements from ATAP or TANF. Other examples are to allow Head Start to send immunization records to your child's local school when he/she transitions to kindergarten, or request current immunization, physical or dental exam records from your child's health care providers. Your written consent is required to legally release and exchange information. This Request to Release & Exchange Information form allows us to share this information between programs/agencies.

All information gathered is kept confidential and released only when your permission is given. Parents and legal guardians of Head Start children have the right to access their child(ren)'s files at the Head Start center as well as at the Head Start Central Office located in Juneau, Alaska.

CHILD'S FIRST & LAST NAME:	**CHILD'S DATE OF BIRTH:**

Alaska Temporary Assistance Program (**ATAP**) Benefits-Case worker: _____
Temporary Assistance for Needy Families (**TANF**) Case worker: _____
Last Four of Social Security Number (**SSN**): _____
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 exchangedbetween Tlingit & Haida Head Start:

PROVIDE CLINIC NAMES (REQUIRED):
Dental Records / Name of Clinic: _____
Medical Records & WIC / Name of Clinic: _____
Immunization & TB Test Records/Name of Clinic: _____

Please fill out if you receive these services for your child:
NAME OF AGENCY (REQUIRED):
Infant Learning Program (ILP) / or Other Program: _____
Developmental Screening and Assessment Information at: _____
Individualized Education Program (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 & Haida Indian Tribes of Alaska - Head Start**
Address: 3100 Channel Drive Ste. 300 Juneau, AK 99801	**Address:** P.O. Box 25500 Juneau, AK 99802
Contact Number: 907.463.6630	**Contact Number:** 1.800.344.1432/x7127
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:

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Tuberculosis Risk Assessment Form

Date: _____

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 closecontact 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 countryin western or northern Europe	☐ Yes
Immunosuppression, current or planned • HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids for morethan 2 weeks (i.e., equivalent of prednisone ≥ 2 mg/kg/day, or ≥ 15mg/day for ≥ 2 weeks), or other immunosuppressive medication.	☐ Yes

IF 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 evaluationand parents/guardians will be notified.

PARENT/GUARDIANSIGNATURE:	**DATE:**

SUBMIT