CHUGACHMIUT HEAD START AND EARLY HEAD START
BIRTH TO 5 PROGRAM
APPLICATION

NANWALEK *PORT GRAHAM*

SCHOOL YEAR 2024-25

Head Start Central Office Admin: 1840 Bragaw Street, Suite 110, Anchorage, AK 99508
Phone: 1(800) 478-4155 ext. 144 **email:** headstart@chugachmiut.org **Fax:** 1-800-793-2891 Attn: Head Start
website: www.chugachmiut.org

Child's Name: _____ Application Date: _____

Application Checklist:

- ☐ **Child application** – completed, signed, and dated.
- ☐ **Income Verification** – one of the following from the last 12 months

__ income tax return	__ copy of W-2
__ pay stubs	__ ATAP/TANF
__ unemployment documents (if applicable)	__ no income statement
__ SNAP approval letter or Quest Card	

- ☐ **Proof of child's birthdate** – one of the following

__ birth certificate or hospital birth record	__immunization record

- ☐ **Proof of legal/foster/relative guardianship** (if not the child's biological parents)
- ☐ **Release of Information**
- ☐ **IFSP/IEP** (if applicable) **I**ndividualized **F**amily **S**ervices **P**lan or **I**ndividualized **E**ducation **P**lan
- ☐ **Current immunization record** (needed before 1st day of attendance)
- ☐ **Current Physical due within 90 days of enrollment** (current within the last 12 months)

Once your child is accepted into the program, additional enrollment paperwork will be completed with your child's teacher.

Priority is given to those that meet the 2024 Federal Poverty Guidelines for Alaska.

2024 POVERTY GUIDELINES FOR ALASKA

1	$18,810
2	$25,540
3	$32,270
4	$39,000
5	$45,730
6	$52,460
7	$59,190
8	$65,920

For families/households with more than 8 persons, add $6,730 for each additional person.

A child who is homeless or in foster care is eligible even if the family income exceeds the income guidelines

Homeless means any individual who lacks fixed, regular and adequate residence. EX: living with family in their house, in a car, shelter, or places not meant for habitation, or living in a dwelling you do not pay for yourself

STAFF USE ONLY:

This application and eligibility interview was conducted:

_____ In-Person _____ Phone/Zoom (state why)

This institution is an equal opportunity provider

Staff Initial _____

Chugachmiut Head Start
Birth to 5 Program
Enrollment Application

Community:_____ **Year: 24-25**

Program Applying for: check one ☐ **Head Start** (age 3-5) ☐ **Early Head Start** (age birth to 3)

Is child transitioning from Early Head Start? check one ☐ Yes ☐ No

Section 1: Child Information *Please Print Clearly*

First	Middle	Last	Nickname	Date of Birth	Gender

Race		Hispanic	Is this child in OCS or State custody?	Child Primary Language:	Child Secondary Language:
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial _____	☐ Yes ☐ No	☐ Yes ☐ No If yes, please provide a copy of documentation.	_____ ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ Little ☐ Moderate ☐ Proficient

Tribally Enrolled: ☐ Yes ☐ No Tribe Name:

Section 2: Primary Adult

First	Middle	Last	Suffix	Nickname	Date of Birth	Gender

Primary Phone:	Alternate Phone	E-Mail

How would you like to receive program information? ☐ Mail ☐ E-mail ☐ Text/FB message (msg. & data rates apply)

Race		Hispanic	Primary Language	Other Language	Military Status
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial _____	☐ Yes ☐ No	_____ ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ Little ☐ Moderate ☐ Proficient	☐ Active ☐ Veteran ☐ None

Highest Grade Completed	Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Highest Grade: _____ ☐ GED ☐ HS Graduate ☐ Associate's ☐ Bachelor' ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Section 3: Secondary or Other Adult

First	Middle	Last	Suffix	Nickname	Date of Birth	Gender

Primary Phone:	Alternate Phone	E-Mail

How would you like to receive program information? ☐ Mail ☐ E-mail ☐ Text/FB message (msg. & data rates apply)

Race		Hispanic	Primary Language	Other Language	Military Status
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial _____	☐ Yes ☐ No	_____ ☐ Little ☐ Moderate ☐ Proficient	_____ ☐ Little ☐ Moderate ☐ Proficient	☐ Active ☐ Veteran ☐ None

Highest Grade Completed	Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Highest Grade: _____ ☐ GED ☐ HS Graduate ☐ Associate's ☐ Bachelor's ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

Staff Initial:

This institution is an Equal Opportunity provider.

Child's Name: _____ DOB: _____ Community: _____

Section 4: Family Information

PHYSICAL ADDRESS:	MAILING ADDRESS:
Address: _____	Address: _____
City: _____ AK zip _____	City: _____ AK zip _____

Housing: (check one)	☐ Own ☐ Rent ☐ Neither	How long at physical address?	
Are you currently homeless?	☐ Yes ☐ No (lack of fixed, regular, and adequate nighttime residence, or live in a dwelling you do not pay for yourself)		
Primary Language at Home:		Learning any other language?	☐ Yes If yes, what language? ☐ No
Are you or anyone in your household experiencing any crisis?	☐ Yes ☐ No (if yes, please explain)		
Indicate Family Type:	☐ Single Parent Family ☐ Two Parent Family ☐ Foster Family ☐ Grandparent(s) ☐ Other Relative		

Please list below everyone living in your household beginning with the head of household. Also include the child that you are applying for:

Name (Last, First)	Date of Birth	Relationship to Child	Employed (FT/PT)	In School (FT/PT)
1.				
2.				
3.				
4.				
5.				
6.				

*Please attach additional page if necessary

Total Number of Adults:		Total Number of Children:	
Does the child applicant currently have a sibling enrolled in the program?		☐ Yes ☐ No	
Was your family referred for services by a child welfare agency? (OCS, ICWA, CITC etc.)	Are there any existing plans with other agencies?	Services your Family Receives: (Check all that apply)	
☐ Yes ☐ No	☐ Yes ☐ No If yes please explain:	☐ TANF/ATAP ☐ SNAP/FOOD STAMPS ☐ WIC	☐ SSI ☐ UNEMPLOYMENT ☐ OTHER:

Section 5: Child Health Information

Primary Health Coverage/Insurance:	Medical Service Provider:	Dental Service Provider:
☐ Denali Kid Care/Medicaid ☐ Private ☐ IHS ☐ Other	☐ Port Graham Clinic ☐ Nanwalek Clinic ☐ Other	☐ Port Graham Clinic ☐ Nanwalek Clinic ☐ Other

Is your child Potty Trained?	☐ Yes ☐ No
Does your child have any diagnosed food or medical allergies? ***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.**	☐ Yes* ☐ No If yes, please explain:
Do you have any health concerns for your child?	☐ Yes ☐ No If yes, please explain:
Do you have any developmental concerns about your child?	☐ Yes ☐ No If yes, please explain:
Is your child currently being evaluated for an IEP or IFSP?	☐ Yes ☐ No
Does your child have a current or expired IEP or IFSP? ***If Yes, please attach copies of the IEP or IFSP or Release of Information Form**	☐ Yes* ☐ No

Staff Initial: _____

Child's Name: DOB: Community:

Section 6: Income/Eligibility Verification

Type of Income Verified:		
☐ Income Tax Return ☐ Copy of W-2 ☐ Pay Stubs ☐ Unemployment documents (if applicable) ☐ No Income **Need to sign additional form**	☐ ATAP/TANF ☐ SSI ☐ SNAP (certificate of services) ☐ Other:	☐ Homeless **Need to sign additional form** ☐ Foster Care ☐ IFSP/IEP

Annual income amount for Primary Parent/Legal Guardian:	$
Annual income amount for Secondary Parent/Legal Guardian:	$
Alaska Permanent Fund Dividend or other Income Source:	$
Number of PFD's received in household _____ X Amount of PFD: _____	TOTAL annual income of family: $

Section 7: Parent Authorizations

The following are Head Start services that require parental consent. These services are completed by qualified specialists and/or trained Head Start staff. Unless revoked in writing, authorization is valid for up to 3 years while enrolled in the Head Start program. Please initial all applicable areas:

_____ **For Basic First Aid:**
I authorize Head Start staff to administer basic first aid to my child during program hours.

_____ **For Health Screenings:**
I authorize Head Start or other qualified specialist to conduct hearing, vision, height and weight screens.

_____ **For Developmental Screenings:**
I authorize Head Start staff to conduct developmental screenings on my child to assess their development.

_____ **For Classroom Observations:**
I authorize my child to participate in behavioral observations in a group setting. If an individual child observation is indicated, parental authorization will be requested.

_____ **For Pictures & Video Recordings:**
I authorize that pictures and/or video recordings of my child taken during Head Start activities are used for the purposes of Educational Observations (school readiness observations) and/or may be used in print media-online media and social media and marketing material or other Chugachmiut publications.

_____ **For Field Trips:**
I authorize my child to attend all Head Start field trips outside the Head Start facility.

_____ **For Exchange of Information:**
I agree to allow Head Start to share my information within Chugachmiut

_____ **For Release of Contact Information:**
I authorize for my phone number and email address to be released to the local Parent Committee for Head Start activities.

_____ **For Records:**
I agree to provide Head Start a copy of my child's immunization record, TB screening withresults, Medical Statement for allergies (if applicable), prior to enrollment. I will provide a well-child check/physical exam, including blood pressure & hemoglobin results, lead screen and dental exam within 90 days of enrollment.

_____ **For Lead Screens:**
I agree to permit Head Start to obtain a copy of the lead screen results from the clinic or provider.

Section 8: CACFP Enrollment

Hours attending	Days	Meals (Circle all that apply)
to	M T W TH F	Breakfast AM Snack Lunch PM Snack Supper

Is this child a Foster Child? ☐ Yes ☐ No

Section 9: Agreement

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 Chugachmiut Head Start 0-5 Program. 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:
Chugachmiut Head Start Staff Signature:	Date:

Staff Initial: _____

CHUGACHMIUT
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone #: _____

RECIPIENT

I authorize Chugachmiut to use/disclose my PHI to the following individual(s) or entity(-ies):

Chugachmiut Birth to 5 Head Start

USE OF INFORMATION

The information will be used/disclosed for the following purpose:

☐ At the request of the client; or

☒ Other (describe in detail): To meet Chugachmiut Birth to 5 Head Start Health Requirements

FORM OF INFORMATION

☒ I authorize Chugachmiut to disclose copies of my records as described in this form.

☒ I authorize Chugachmiut and its staff to verbally discuss my records as described in this form.

TYPE OF INFORMATION

DATE RANGE OF RECORDS: 5/30/24 **TO** 5/29/25

I authorize disclosure of the following PHI:

☒ History & Physical ☐ Discharge Summary

☐ Operative Report ☐ Emergency Department Report

☐ Diagnostic Reports (lab, x-ray, EKG, etc.)

☒ Other (specify): Dental exams and screenings, Lead screenings and results, Hemoglobin results, Immunization Records.

LENGTH OF AUTHORIZATION

Unless revoked, this authorization expires on: _____
If left blank, this authorization will expire 365 days from the date of the client's signature.

APPLICABLE LAW

By signing this authorization form, I understand and agree that:

- My PHI is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent except for certain purposes allowed by HIPAA as described in Chugachmiut's Notice of Privacy Practices.

- My PHI may include my social security number.

- If the person or entity receiving the PHI is not a health care provider or health plan covered by HIPAA, the PHI may re-disclosed without protection by HIPAA, but may be covered by other laws protecting information on HIV/AIDS, mental health services, or genetic testing.

- I may revoke this authorization in writing at any time by notifying Chugachmiut, except to the extent that Chugachmiut has already used or disclosed information in reliance on my authorization.

- Chugachmiut may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except in certain circumstances provided by HIPAA.

- I may request a copy of this authorization. Chugachmiut will also provide me a copy if it sought this authorization from me.

SIGNATURE

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Legal Guardian or Personal Representative Date

_____

Printed name of Parent, Legal Guardian or Personal Representative

_____

Description of Authority (if applicable)

**Note: Chugachmiut requires Legal Guardians and Personal Representatives to provide written verification of their authority to act on behalf of a patient.*

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For Chugachmiut's Use Only:

Date Received: _____

Name/Title of Staff Member Processing Request: _____