# APIA Head Start
# Enrollment Process

APIA
ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
*With Spirit and Strength*

## STEP 1: Application Process

Enrollment Application Form Must be completed in Person:

1. Complete Head Start Application with Staff & Provide Child's Birth Certificate.
2. *If applicable:* Provide Proof of Legal/Foster/Relative Guardianship.
3. *If applicable: Provide Proof of TANF/SNAP, SSI, or Current Housing Status.*
4. Income Verification for last 12 months of Income *(copies of W-2, 1040 Tax Return, Pay stubs, Unemployment, Child Support, or Self Declaration form for no income, etc.)*

Prepare to discuss and verify documents submitted with application

*NOTE: Current Housing Status is considered; lacks a fixed, regular and adequate nighttime residence. Including sharingthe housing of other persons. Living in motels, hotels, camping grounds due to the lack of alternative accommodations. Living in emergency or transitional housing or abandoned.*

*A Child is automatically eligible when/if in foster care.*

## STEP 2: Application Review Process

1. Family Engagement Coordinator will process application according to eligibility and selection criteria
2. If additional information is needed family will be notified.
3. Once verification is complete and child is accepted into program or placed on waitlist, family will be contacted to schedule first Orientation/Home Visit.

## Records Required for Enrollment

Please be prepared to bring the following documents to the Orientation/Home Visit meeting:

- ☐ **Immunizations:** Most up to-date immunization record of your child, or may present religious/medical exemption.
- ☐ **Physical Exam:** A comprehensive head-to-toe examination performed by the Medical Provider, physical exam should also include:
  - **Hemoglobin Test:** This shows if the individual has anemia (low iron).
  - **Height and Weight:** This shows if a child is growing and gaining weight normally. Poor growth and weight gain can indicate health problems or disease.
  - **Blood Pressure:** This determines heart and blood pressure. high blood pressure in a child will easily identify a kind of renal tumor that usually happens among children between the ages of 3-5
  - **Vision Screening:** This shows if a child can see normally. If a child cannot see well he or she will have difficulty learning.
  - **Hearing Screening:** Measures how well a child can hear certain sounds. Hearing problems can lead to speech, language and other learning difficulties.
  - **PPD Test/ TB Test:** This identifies people who have been exposed to Tuberculosis and helps prevent the spread of Tuberculosis to others. All children must have a PPD test before beginning school.
  - **Dental Exam:** This is a check-up by the dentist to look for decay in the teeth and disease in the mouth. Severe tooth decay and gum disease can cause poor appetite and nutritional or speech problems. We recommend a dental check up every 6 months for your child beginning at 6-months of age.
  - **Lead Screen Test*:** This screen detects the risk for lead poisoning by measuring the amount of lead in the blood stream. Lead exposure can cause impaired learning ability. If your child has never been screened for Lead, we highly recommend screening to help prevent future exposure.

Included in Enrollment packet:

- ☐ **CACFP Child Enrollment Form:** This shows verification of enrollment for each participant in the program and identifies the meal service provided to your child.
- ☐ **Medical Statement:** to request special meals and/or accommodations. Must be filled out by a Medical Authority.
- ☐ **Release of Information/ROI**
- ☐ **Emergency Record Card**
- ☐ **Parent Authorizations**

## STEP 3: Enrollment

It is APIA Head Start Policy to receive all health information prior to enrollment

1. Teacher will schedule a parent Orientation/Home Visit
2. Health documents will be submitted to Health Coordinator for verification.
3. Upon verification of health requirements parent and teacher will establish first day of enrollment, and notify date to ERSEA Coordinator.

## Applications may be turned in to Head Start in the following ways:

| | |
|---|---|
| In Person | At your local APIA Head Start Center |
| Mail | Aleutian Pribilof Islands Association, Inc.<br>Attn: Head Start 1131 E. Int'l Airport Rd.<br>Anchorage, AK 99518 |
| Fax | 1-907-279-4351 Attn: Head Start |
| e-mail | anchoragehs@apiai.org |

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# APIA Head Start
# Program Application

Site:_____ Date:_____

APIA
ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
*With Spirit and Strength*

## CHILD INFORMATION

**Child's full name:** | **DOB:** | **Gender:**

**Race:**
☐Alaska Native ☐Asian
☐American Indian ☐Pacific Islander/Native Hawaiian
☐African American/Black ☐Other (*please specify):*
☐Caucasian/ White

**Ethnicity:**
☐Hispanic
☐Non-Hispanic

**Tribal Affiliation**
☐Agadaagux ☐St. Paul
☐Belkofski ☐Unga
☐Qagan Tayagungin ☐Pauloff Harbor
☐Qawalangin ☐N/A
☐Other:

**Child's Primary Language:** _____
**Proficiency:** _____

**Child's Secondary Language:** _____
**Proficiency:** _____

***Language Proficiency levels:***

*Little = **L**, Moderate = **M**, Proficient = **P***

## PRIMARY ADULT

**Primary Adult Full Name:** | **DOB:** | **Gender:**

**Primary Phone:** ☐home ☐cell ☐work | **Alternate Phone:** ☐home ☐cell ☐work

**Email:** | **Contact Preferences** (*select all that apply*): ☐Phone Call ☐Text ☐Email

**Primary Language**: **Proficiency** *(L, M, P):* | **Secondary Language:** **Proficiency** *(L, M, P):*

**Race:**
☐Alaska Native ☐Asian
☐American Indian ☐Pacific Islander/Native Hawaiian
☐African American/Black ☐Other: (*please specify*):
☐Caucasian/White

**Tribal Affiliation:**
☐Agadaagux ☐ Qawalangin
☐Belkofski ☐Unga
☐Pauloff Harbor ☐Other:
☐St. Paul ☐N/A
☐Qagan Tayagungin

**Are Translation Services Needed?** ☐ Yes ☐No

**Ethnicity:**
☐Hispanic
☐Non-Hispanic

**U.S Military Status:**
☐Active
☐Veteran
☐N/A

**Relationship to Child:**
☐Parent/Legal Guardian
☐Grandparent
☐Legal Foster Parent
☐Other: _____

**Highest Education Level:**
*(Check One)*
☐Highest Grade: _____
☐High School Graduate ☐AA
☐GED ☐BA
☐COLLEGE ☐MA

**Employment Status:** (Check One)
☐Full Time ☐Full time + School
☐Part Time ☐Part time + School
☐Seasonal ☐Retired or Disabled
☐Training/School ☐Unemployed

## SECONDARY ADULT

**Secondary Adult Full Name:** | **DOB:** | **Gender:**

**Primary Phone:** ☐home ☐cell ☐work | **Alternate Phone:** ☐home ☐cell ☐work

**Email:** | **Contact Preferences** (*select all that apply*): ☐Phone Call ☐Text ☐Email

**Primary Language**: **Proficiency** *(L, M, P):* | **Secondary Language:** **Proficiency** *(L, M, P):*

**Race:**
☐Alaska Native ☐Asian
☐American Indian ☐Pacific Islander/Native Hawaiian
☐African American/Black ☐Other:(*please specify*):
☐Caucasian/White

**Tribal Affiliation:**
☐Agadaagux ☐Qawalangin
☐Belkofski ☐Unga
☐Pauloff Harbor ☐Other:
☐St. Paul ☐N/A
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**Are Translation Services Needed?** ☐ Yes ☐No

**Ethnicity:**
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**U.S Military Status:**
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☐N/A

**Relationship to Child:**
☐Parent/Legal Guardian
☐Grandparent
☐Legal Foster Parent
☐Other: _____

**Highest Education Level:**
*(Check One)*
☐Highest Grade: _____
☐High School Graduate ☐AA
☐GED ☐BA
☐COLLEGE ☐MA

**Employment Status:** (Check One)
☐Full Time ☐Full time + School
☐Part Time ☐Part time + School
☐Seasonal ☐Retired or Disabled
☐Training/School ☐Unemployed

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Child's Name:_____ DOB:_____ Site: _____

| FAMILY INFORMATION | | | |
|---|---|---|---|
| **Physical Address:** | **City:** | **State:** | **Zip Code:** |
| **Mailing Address** *(if different than physical address):* | **City:** | **State:** | **Zip Code:** |

| **Housing:** | **Parental Status:** | **Number of people living in the home:** | **Services your family receives:** *(check all that apply)* |
|---|---|---|---|
| ☐Own<br>☐Rent<br>☐Neither | ☐One Parent<br>☐Two Parent<br>☐Teen Parent *(age 19 or under)* | Number of Adults: Number of Children: Total: _____ | ☐None<br>☐Child Care Assistance<br>☐SNAP/Food Stamps<br>☐WIC<br>☐Indian Health Services (HIS)<br>☐TANF/TAP<br>☐Supplemental Security Income<br>☐Other_____ |

**Please list below all the members of the household:**

| Full Name: | Date of Birth: | Gender: | Relationship to Child: |
|---|---|---|---|
| Full Name: | Date of Birth: | Gender: | Relationship to Child: |
| Full Name: | Date of Birth: | Gender: | Relationship to Child: |
| Full Name: | Date of Birth | Gender: | Relationship to Child: |

- Do you live in a shelter, transitional housing, motel, vehicle, or in the home of relative or friends? ☐ Yes ☐ No
- Was your family referred for services by a child welfare agency? (OCS, CIT, ICWA, etc.) ☐Yes ☐ No
- Is either parent incarcerated? ☐Yes ☐ No Are there substance abuse issues in the home? ☐Yes ☐ No
- Are there concerns or has there been domestic violence in the home? ☐Yes ☐ No

**TRANSPORTATION**

Are transportation services needed? ☐ Yes ☐No

**CHILD HEALTH INFORMATION**

| **Primary Health Coverage/Insurance:** | **Doctor/Medical Clinic Name:** | **Phone:** |
|---|---|---|
| ☐Denali Kid Care/Medicaid<br>☐Private<br>☐Other:_____<br>☐None | **Dentist/Dental Clinic Name:** | **Phone:** |

**Do you have concerns about your child's overall health and development?** ☐**Yes** ☐ **No** *if yes, please describe

**Has your child been diagnosed with a chronic health condition?** ☐**Yes** ☐ **No** *if yes, please describe

**Does your child have any diagnosed food or medical allergies?** ☐**Yes** ☐ **No**

*if your child has a food allergy, please complete the "Medical Statement" form

**Is your Child currently receiving medical treatment for a diagnosed condition?** ☐**Yes** ☐ **No** *if yes, please describe

**Does your child wear diapers, pull ups or need assistance using the bathroom?** ☐**Yes** ☐**No**

**CHILD IEP/IFSP**

**Is your child currently being evaluated for an IEP (Individualized Education Plan) or IFSP (Individualized Family Service Plan)?**

☐Yes ☐No

**Specify Program Name:**_____

**Does your child have a current or expired IEP or IFSP?**
☐Yes ☐ No

**Please attach copies of the:**
☐ IEP ☐ IFSP or ☐Signed Release of Information Form

**AGREEMENT**

**I certify that the above information is true to the best of my knowledge. I understand that the information in this application will be held in strict confidence within the agency and is accessible to me during business hours.**
**If any part is proven false, your child's status may be changed.**

**Parent/Guardian Signature:** **Date:**

**APIA Head Start Staff Signature:** **Date:**

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