APIA Head Start
Enrollment Process

ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
With Spirit and Strength

STEP 1: Application Process

Enrollment Application Form Must be completed in Person:

1. During the initial parent meeting, family will complete the Head Start Application & 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. APIA Head Start's definition of "homeless children" is based from The McKinney-Vento Homeless Assistance Act.

***If documentation is provided, child is eligible for services.*

STEP 2: Application Review Process

1. The application will be processed according to eligibility/selection criteria. If additional information is needed, the family will be notified.
2. Once verification is complete, families will be informed and the enrollment process will begin.
3. Records required below must be provided to complete enrollment.
4. Teachers will schedule the first Home Visit to review the Enrollment Packet.

Health 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 weightgain can indicate health problems or disease.
  - **Blood Pressure:** This determines heart and blood pressure. High blood pressure in a child will easily identifya 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 havedifficulty learning.
  - **Hearing Screening:** Measures how well a child can hear certain sounds. Hearing problems can lead tospeech, language and other learning difficulties.
  - **PPD Test/ TB Test:** This identifies people who have been exposed to Tuberculosis and helps prevent thespread 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 theblood stream. Lead exposure can cause impaired learning ability. If your child has never been screened forLead, 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.
- ☐ **Emergency Record Card**
- ☐ **Parent Authorizations**
- ☐ **Release of Information/ROI** *(If applicable)*
- ☐ **Medical Statement:** to request special meals and/or accommodations. Must be filled out by a Medical Authority.

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 submitted by the following ways:

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

APIA Head Start
Program Application

APIA
ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
With Spirit and Strength

Community: ☐KVC ☐SDP ☐UNA (AM) ☐UNA (PM)

CHILD INFORMATION

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

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

Ethnicity:
☐Hispanic
☐Non-Hispanic

Tribal Affiliation
☐Agadaagux
☐Belkofski
☐Qagan Tayagungin
☐Qawalangin
☐St. Paul
☐Unga
☐Pauloff Harbor
☐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
☐American Indian
☐African American/Black
☐Caucasian/White
☐Asian
☐Pacific Islander/Native Hawaiian
☐Other: _____ *(please specify)*

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

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
☐GED
☐Some College
☐AA
☐BA
☐MA
☐PhD

Employment Status *(Check One)*:
☐Full Time
☐Part Time
☐Seasonal
☐Training/School
☐Full Time + School
☐Part Time + School
☐Retired or Disabled
☐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
☐American Indian
☐African American/Black
☐Caucasian/White
☐Asian
☐Pacific Islander/Native Hawaiian
☐Other: _____ *(please specify)*

Tribal Affiliation
☐Agadaagux
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☐Other: _____
☐St. Paul
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☐N/A

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
☐GED
☐Some College
☐AA
☐BA
☐MA
☐PhD

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

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

FAMILY INFORMATION

Physical Address: **City:** **State:** **Zip Code:**

Mailing Address *(if different from above)*: **City:** **State:** **Zip Code:**

Housing:	**Parental Status:**	**People living in the home:**	**Annual Income** (within the previous 12 months)**:**	**Services your family receives** *(check all that apply)*:
☐Own ☐Rent ☐Employer-provided ☐Other (please specify): _____	☐One Parent ☐Two Parent ☐Teen Parent (age 19 or under)	# of Adults: _____ # of Children: _____ Total: _____	$_____	☐None ☐Child Care Assistance ☐SNAP/Food Stamps ☐Indian Health Services (IHS) ☐TANF/TAP ☐WIC ☐Supplemental Security Income ☐Other _____

Please list below all the members of the household *(excluding the child who is applying)*:

Full Name:	Date of Birth:	Gender:	Relationship to Child:
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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 (depending on site availability)? ☐Yes ☐ No

CHILD HEALTH INFORMATION

Primary Health Coverage/Insurance:	**Doctor/Medical Clinic Name:**	**Phone:**
☐Denali Kid Care/Medicaid ☐Private ☐Other _____ ☐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 (IndividualizedEducation 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 instrict 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:**

Head Start Program
Physical Form

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Childs Name:		Date of Exam:
Child's Age:	Child's DOB:	Parent/Guardian's Name:
Height (inches):	Weight(lbs):	Blood Pressure: ☐ Attempted ☐ Child Refused

Risk Factors Reviewed

		Normal	Abnormal	Refer	Not Examined	Notes
1	General Appearance					
2	Posture, Gait					
3	Skin					
4	Eyes					
5	Ears					
6	Nose, Mouth, Pharynx					
7	Teeth/Gums					
8	Heart					
9	Lungs					
10	Abdomen					
11	Bones, joints, muscles					
12	Gross Motor					
13	Fine Motor					
14	Glands (Lymphatic/Thyroid)					
15	Muscular Coordination					

Disease Prevention and Recommendations

1	Is child up to date on schedule of age appropriate preventative and primary health care? ☐ Yes ☐ No **Notes:**
2	Does child need to establish any of the following services? ☐ Routine Dental Care ☐ Routine Hearing Screening ☐ Mental Health ☐ Evaluation by Registered Dietician ☐ Speech & Language ☐ Other:
3	List any acute or chronic conditions including allergies, if any:
4	Child's Status was determined by: ☐ Parent Report ☐ Medical History ☐ Today's Exam

Mandatory Head Start Tests

Hemoglobin Result: ☐ Normal ☐ Abnormal	Lead Screening Result: ☐ Normal ☐ Abnormal
Tuberculosis Disease Symptom Screening Form Date Signed:	Comment

Provider Information

Provider Name:	Provider Signature:	Date: