

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 on The McKinney-Vento Homeless Assistance Act. <i>**If documentation is provided, child is eligible for services.</i>		
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 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. ☐ Emergency Record Card ☐ Parent Authorizations ☐ Release of Information ☐ 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:		Reporting
In Person	At your local APIA Head Start Center	To Report FRAUD or ABUSE of Head Start funds, please call APIA's Department of Family and Community Development, Head Start Division at (907)276-2700 or toll free at 1(800)478-2742
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	

Department of Family and Community Development
Head Start Program APPLICATION FOR SERVICES



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

CHILD INFORMATION

Child's full name:			DOB:	Gender:	
Race (if multiracial select all that apply): ☐ Alaska Native/American Indian ☐ Asian ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White ☐ Other: _____	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Tribal Affiliation ☐ Agadaagux ☐ St. Paul ☐ Belkofski ☐ Unga ☐ Qagan ☐ Pauloff Harbor ☐ Tayagungin ☐ Qawalangin ☐ N/A ☐ Other: _____	Child's Primary Language: _____	Child's Secondary Language: _____	
			Language Proficiency levels: Little=L, Moderate=M, Proficient = P		Proficiency: _____
			Language Spoken at home: _____		

PRIMARY ADULT

Primary Adult Full Name:			DOB:	Gender:
Primary Phone:	☐ home ☐ cell ☐ work		Alternate Phone:	☐ home ☐ cell ☐
Email:	Contact Preferences (select all that apply): ☐ Phone Call ☐ Text ☐ Email			
Primary Language:	Secondary Language:	Proficiency (L, M, P):		
Race (if multiracial select all that apply): ☐ Alaska Native/American Indian ☐ Asian ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White ☐ Other: _____	Tribal Affiliation ☐ Agadaagux ☐ St. Paul ☐ Unga ☐ Belkofski ☐ Pauloff Harbor ☐ Qagan Tayagungin ☐ Qawalangin ☐ Other: _____ ☐ N/A		Are Translation Services Needed? ☐ Yes ☐ No	
	Ethnicity: ☐ Hispanic ☐ Non-Hispanic		U.S. Military Status: ☐ Active ☐ Veteran ☐ N/A	Relationship to Child: ☐ Biological/Adopted/Step ☐ Foster ☐ Grandchild ☐ Other: _____
			Custody: ☐ Yes ☐ No	
Relationship to Child: ☐ Parent/Legal Guardian ☐ Grandparent ☐ Legal Foster Parent ☐ Other: _____	Highest Education Level (Check One): ☐ Highest Grade: _____ ☐ AA ☐ High School Graduate ☐ BA ☐ GED ☐ MA ☐ Some College ☐ PhD		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 ☐
Email:	Contact Preferences (select all that apply): ☐ Phone Call ☐ Text ☐ Email			
Primary Language:	Secondary Language:	Proficiency (L, M, P):		
Race (if multiracial select all that apply): ☐ Alaska Native/American Indian ☐ Asian ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White ☐ Other: _____	Tribal Affiliation ☐ Agadaagux ☐ St. Paul ☐ Unga ☐ Belkofski ☐ Pauloff Harbor ☐ Qagan Tayagungin ☐ Qawalangin ☐ Other: _____ ☐ N/A		Are Translation Services Needed? ☐ Yes ☐ No	
	Ethnicity: ☐ Hispanic ☐ Non-Hispanic		U.S. Military Status: ☐ Active ☐ Veteran ☐ N/A	Relationship to Child: ☐ Biological/Adopted/Step ☐ Foster ☐ Grandchild ☐ Other: _____
			Custody: ☐ Yes ☐ No	
Relationship to Child: ☐ Parent/Legal Guardian ☐ Grandparent ☐ Legal Foster Parent ☐ Other: _____	Highest Education Level (Check One): ☐ Highest Grade: _____ ☐ AA ☐ High School Graduate ☐ BA ☐ GED ☐ MA ☐ Some College ☐ PhD		Employment Status (Check One): ☐ Full Time ☐ Full Time + School ☐ Part Time ☐ Part Time + School ☐ Seasonal ☐ Retired or Disabled ☐ Training/School ☐ Unemployed	

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

FAMILY INFORMATION

Physical Address:		City:	State:	Zip Code:
Mailing Address <i>(if different from above):</i>		City:	State:	Zip Code:
Housing: ☐ Own ☐ Rent ☐ Employer-provided ☐ Other (please specify): _____	Parental Status: ☐ One Parent ☐ Two Parent ☐ Teen Parent (age 19 or under)	Annual Income (within the previous 12 months): \$ _____	Services your family receives <i>(check all that apply):</i> ☐ None ☐ WIC ☐ Child Care Assistance ☐ TANF/TAP ☐ SNAP/Food Stamps ☐ Supplemental Security Income ☐ Tribal Food Programs ☐ Other _____	

People living in the home: # of adults: _____ **# of children:** _____ **Total:** _____

Please list below all the members of the household, excluding the child who is applying (continue on back page if needed):

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 (depending on site availability)? ☐ Yes ☐ No

CHILD HEALTH INFORMATION

Primary Health Coverage/Insurance: ☐ Children's Health Insurance Program (CHIP) ☐ Combined Medicaid/CHIP ☐ Private ☐ Medicaid ☐ State-Only Funded Insurance ☐ No Insurance ☐ Other: _____	Doctor/Medical Clinic Name: Dentist/Dental Clinic Name:	Phone: Phone:
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Do you authorize Head Start staff to assist you in applying for health insurance if needed? ☐ Yes ☐ No

Do you have concerns about your child's overall health and well-being? ☐ 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 *if yes, please complete Medical Statement Form ☐ No

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, program name: _____ ☐ No ☐ No, but we suspect a developmental delay and would like to be evaluated

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

If yes, 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:

Head Start Program Physical Form



Child's 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: