



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

2024-2025 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@tingitandhaida.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:

<input type="checkbox"/>	Head Start Application
<input type="checkbox"/>	Income Verification - At least one of the following documents are required per working adult(s) in the home: <ul style="list-style-type: none"> • 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 or 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.
<input type="checkbox"/>	Immunization Records
<input type="checkbox"/>	Child's TB Risk Assessments Questionnaire
<input type="checkbox"/>	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@tingitandhaida.gov

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

This institution is an equal opportunity provider.

2024-2025 Tlingit & Haida Head Start Application

SECTION A	CHILD INFORMATION			
FULL FIRST NAME:	FULL MIDDLE NAME:	FULL LAST NAME:	SUFFIX:	
NICKNAME:	DOB:			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RACE: <i>(Choose all that apply)</i> <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian	ETHNICITY: <i>(Choose one)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	CHILD PRIMARY LANGUAGE: _____ <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	CHILD SECONDARY LANGUAGE: _____ <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	
SECTION B	PRIMARY ADULT			
FIRST NAME:	LAST NAME:	DOB:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PRIMARY LANGUAGE:		Translation or Interpretation Services Needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
RACE: <i>(Choose all that apply)</i> <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian	ETHNICITY: <i>(Choose one)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	MILITARY STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Veteran		
		PRIMARY PHONE: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Able to receive text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		ALTERNATE PHONE: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Able to receive text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		E-MAIL: _____		
RELATIONSHIP TO CHILD: <i>(Check one)</i> <input type="checkbox"/> Parent Legal Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Foster Parent <i>(Attach letter)</i> <input type="checkbox"/> Other: _____	HIGHEST EDUCATION LEVEL: <i>(Check one)</i> <input type="checkbox"/> Highest Grade: _____ <input type="checkbox"/> AA <input type="checkbox"/> High School Graduate <input type="checkbox"/> BA <input type="checkbox"/> GED <input type="checkbox"/> MA or Higher <input type="checkbox"/> COL	EMPLOYMENT STATUS: <i>(How many months working?)</i> <input type="checkbox"/> FT only _____ <input type="checkbox"/> FT and School _____ <input type="checkbox"/> PT only _____ <input type="checkbox"/> PT and School _____ <input type="checkbox"/> Seasonal _____ <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training/School <input type="checkbox"/> Unemployed		
SECTION C	SECONDARY ADULT			
FIRST NAME:	LAST NAME:	DOB:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PRIMARY LANGUAGE:		Translation or Interpretation Services Needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
RACE: <i>(Choose all that apply)</i> <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian	ETHNICITY: <i>(Choose one)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	MILITARY STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Veteran		
		PRIMARY PHONE: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Able to receive text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		ALTERNATE PHONE: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Able to receive text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		E-MAIL: _____		
RELATIONSHIP TO CHILD: <i>(Check one)</i> <input type="checkbox"/> Parent Legal Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Foster Parent <i>(Attach letter)</i> <input type="checkbox"/> Other: _____	HIGHEST EDUCATION LEVEL: <i>(Check one)</i> <input type="checkbox"/> Highest Grade: _____ <input type="checkbox"/> AA <input type="checkbox"/> High School Graduate <input type="checkbox"/> BA <input type="checkbox"/> GED <input type="checkbox"/> MA or Higher <input type="checkbox"/> COL	EMPLOYMENT STATUS: <i>(How many months working?)</i> <input type="checkbox"/> FT only _____ <input type="checkbox"/> FT and School _____ <input type="checkbox"/> PT only _____ <input type="checkbox"/> PT and School _____ <input type="checkbox"/> Seasonal _____ <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training/School <input type="checkbox"/> Unemployed		
Secondary Adult Lives with Primary Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No* *If NO, is there a Custody Agreement? <input type="checkbox"/> Yes <i>(Attach documentation)</i> <input type="checkbox"/> No				

USDA and this institution are equal opportunity providers and employers. Parent/Guardians have the right to receive translation or interpretation services in their primary 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) <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Neither
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PARENTAL STATUS: (Check one) <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Was your family referred for services by a child welfare agency? (Office of Children's Services, Child in Transition, ICWA, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	SERVICES YOUR FAMILY RECEIVES: (Check all that apply) <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> SNAP/Food Stamps <input type="checkbox"/> WIC <input type="checkbox"/> Indian Health Services (IHS) <input type="checkbox"/> TANF/ATAP <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> None
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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
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION E CHILD HEALTH INFORMATION

PRIMARY HEALTH COVERAGE/INSURANCE: <input type="checkbox"/> Denali KidCare/Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Other: _____ <input type="checkbox"/> None	DOCTOR/MEDICAL CLINIC NAME: _____ DENTIST/DENTAL CLINIC NAME: _____	PHONE: _____ PHONE: _____
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Does your child have any diagnosed food or medical allergies? Yes* No If YES, please explain: <i>*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.</i>	Does your child take any medications that have to be administered during class time? (Head Start Only) Yes* No <i>*If YES, parent/guardian will be required to fill out a separate medication authorization form prior to the first day of attendance.</i>
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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:
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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 <u>or</u> IFSP <u>or</u> Signed Release of Information Form
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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 digits 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 exchanged between 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



**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 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: <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Disability <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Specialist <input type="checkbox"/> Attorney <input checked="" type="checkbox"/> Head Start School <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____
INFORMATION TO BE DISCLOSED: <input type="checkbox"/> Medical records from the last two years <input type="checkbox"/> Complete Designated Record Set Date(s) of Service: ____/____/____ through ____/____/____ <input type="checkbox"/> Health Summary <input type="checkbox"/> Billing records <input type="checkbox"/> Emergency room records <input type="checkbox"/> Discharge summary <input type="checkbox"/> Physician progress notes <input type="checkbox"/> Nursing notes <input type="checkbox"/> Laboratory/pathology reports <input type="checkbox"/> Radiology reports <input type="checkbox"/> Radiology images <input type="checkbox"/> Medication list <input checked="" type="checkbox"/> Immunization record <input type="checkbox"/> Accounting of disclosures <input type="checkbox"/> Dental chart note <input type="checkbox"/> Dental Pano X-ray <input type="checkbox"/> Dental X-ray <input checked="" type="checkbox"/> 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 <ul style="list-style-type: none"> 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. 	<input type="checkbox"/> Yes
Birth, travel or residence in a country with an elevated TB rate for at least 1 month <ul style="list-style-type: none"> Includes any country other than the United States, Canada, Australia, New Zealand, or a countryin western or northern Europe 	<input type="checkbox"/> Yes
Immunosuppression , current or planned <ul style="list-style-type: none"> HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids for morethan 2 weeks (i.e., equivalent of prednisone \geq 2 mg/kg/day, or \geq 15mg/day for \geq 2 weeks), or other immunosuppressive medication. 	<input type="checkbox"/> Yes
IF NONE OF THE ABOVE APPLY, TB TESTING IS NOT REQUIRED AT THIS TIME.	
Please note: <ul style="list-style-type: none"> Do not repeat TB <u>testing</u> unless there are <i>new</i> 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/GUARDIAN SIGNATURE:	DATE: