



Community: _____

Child is transitioning from: EHS PAT Early Learning Environment None

Program Applying For: Check One	If applicable, the following documents will be required to process your application:	
<input type="checkbox"/> Head Start <input type="checkbox"/> Early Head Start <input type="checkbox"/> Parents as Teachers <input type="checkbox"/> Child Development Center <input type="checkbox"/> DHSS	<input type="checkbox"/> Tax Return (<i>Preferred</i>) <input type="checkbox"/> W-2 <input type="checkbox"/> Check Stubs (<i>Previous 12 months</i>) <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> TANF/ATAP (<i>Previous 12 months</i>) <input type="checkbox"/> Unemployment Statements <input type="checkbox"/> Adult PFD (<i>Parent/Guardian PFDs only</i>)	<input type="checkbox"/> Parent/Guardian Social Security Income <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Income (<i>If you have no income, please complete a "No Income Statement" form</i>) <input type="checkbox"/> Immunization Record <input type="checkbox"/> Consent for Screenings and Program Services <input type="checkbox"/> Release of Information (<i>As needed</i>)

SECTION A CHILD INFORMATION				
FULL FIRST NAME:	FULL MIDDLE NAME:	FULL LAST NAME:	SUFFIX:	
PREFERRED NAME:	DOB:	SOCIAL SECURITY NUMBER:	<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:	<input type="checkbox"/> Translation or Interpretation Services Needed			
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	<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	
	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"/> Grade: _____ <input type="checkbox"/> AA <input type="checkbox"/> HSG <input type="checkbox"/> BA <input type="checkbox"/> GED <input type="checkbox"/> MA <input type="checkbox"/> COL	EMPLOYMENT STATUS: (<i>Check one</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:	<input type="checkbox"/> Translation or Interpretation Services Needed			
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	<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	
	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"/> Grade: _____ <input type="checkbox"/> AA <input type="checkbox"/> HSG <input type="checkbox"/> BA <input type="checkbox"/> GED <input type="checkbox"/> MA <input type="checkbox"/> COL	EMPLOYMENT STATUS: (<i>Check one</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				

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.

CHILD'S NAME: _____ DOB: _____ COMMUNITY: _____

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? (If YES, attach housing form) <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	Custody Agreement? (Attach documentation) <input type="checkbox"/> Yes <input type="checkbox"/> No	SERVICES YOUR FAMILY RECEIVES: (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> SNAP/Food Stamps <input type="checkbox"/> WIC <input type="checkbox"/> Indian Health Services <input type="checkbox"/> TANF/ATAP <input type="checkbox"/> Supplemental Security Income
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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:** _____

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? <input type="checkbox"/> *Yes <input type="checkbox"/> 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) <input type="checkbox"/> *Yes <input type="checkbox"/> No <i>* If YES, parent/guardian will be required to fill out a separate medication authorization form.</i>
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Do you have any health concerns about your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain:	Do you have any developmental concerns about your child? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child have a current or expired IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please attach copies of the: <input type="checkbox"/> IEP <u>or</u> <input type="checkbox"/> IFSP <u>or</u> <input type="checkbox"/> 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 RurAL CAP. I agree to review this information every year. I agree to allow RurAL CAP to share my child's information within RurAL CAP's early childhood programs. All information is kept strictly confidential and I may access it during normal business hours.

PARENT/GUARDIAN SIGNATURE: _____	DATE: _____
RURAL CAP SITE STAFF SIGNATURE: _____	DATE: _____

CENTRAL OFFICE STAFF USE ONLY

TOTAL ANNUAL INCOME: \$ _____	VERIFIED BY NAME: _____	SIGNATURE: _____	DATE: _____				
PRIORITY	<i>Income</i>	<i>Parent Status</i>	<i>Age</i>	<i>Transition</i>	<i>Disability</i>	<i>Other</i>	TOTAL POINTS
CODE							
POINTS							
CONCERN STATUS		PRIMARY CONDITION		IEP/IFSP DATE		MH/D INITIALS	
IMMUNIZATIONS							FHC INITIALS
<input type="checkbox"/> Complete <input type="checkbox"/> Needs <input type="checkbox"/> Exempt <input type="checkbox"/> Up-to-Date							
CLASSROOM		ENROLL STATUS		EFFECTIVE DATE		FHC INITIALS	
C D E H I J		<input type="checkbox"/> Accept <input type="checkbox"/> Waitlist					

**RurAL CAP Head Start/Early Head Start
Consent for Screenings and Programs Services**

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

Parent Authorizations & Agreement		
For Health/Developmental Screenings:		circle one
Basic First Aid: I authorize Head Start staff to administer basic first aid to my child during program hours.		Yes No
Health Screenings: I authorize Head Start and/or a trained medical staff to conduct hearing, vision, and blood pressure screenings, hemoglobin, dental screenings/exams, varnish and fluoride, as well as take growth measurements of my child for the purpose of assessing my child's health status.		Yes No
Developmental Screenings: I authorize Head Start staff to conduct developmental screenings on my child to assess their stages of development.		Yes No
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.		Yes No
For Pictures/Videos:		
Pictures: I authorize that pictures of my child taken during Head Start activities may be used in newspapers, books, displays, brochures or posters for educational and/or publicity purposes.		Yes No
Videos: I authorize Head Start staff to video my child in their classroom for training purposes with early childhood professionals outside of RurAL CAP Head Start. 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.		Yes No
For Records:		
I agree to provide Head Start upon enrollment a copy of my child's immunization record, and Medical Statement for allergies (if applicable).		Yes No
I agree to provide a copy of my child's Well Child Check/Physical Exam (including blood pressure, blood lead screening, TB screening with results & hemoglobin results) and Dental Exams as soon as possible but within 90 days of enrollment and updated as needed.		Yes No
For Culture of Safety:		
I understand Head Start staff are creating a Culture of Safety and need my assistance to talk with my child about staying with their teachers at all times and the importance of never leaving the classroom or group without a teacher.		
CACFP Enrollment:		
Hours attending	Days	Meals (Select all that apply):
to	M T W T H F	<input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper
Infant Formula Selection: Complete if any child listed above is an infant under one year of age.		
Check one: <input type="checkbox"/> I accept the center provided Similac iron fortified infant formula. <input type="checkbox"/> I decline the center provided formula. I understand that by declining the center provided formula, I agree to provide breast milk or formula for my child. If I provide formula it must be on the approved formula list for the center is to be reimbursed for the meal.		
By signing and dating this form, I certify that the information provided on the enrollment application is true and correct. I understand that the information on the application will be held in strict confidence within the agency.		
Parent/Guardian Signature:		Date:
I have received and reviewed the application in-person with the parent/ guardian and certify that the information provided by the parent/ guardian on the enrollment application is true and accurate.		
Staff Signature:		Date: