



Central Council Tlingit and Haida Indian Tribes of Alaska

TLINGIT & HAIDA HEAD START

Mailing Address: P.O. Box 25500 • Juneau, AK 99802

Physical Address: 3800 Mendenhall Loop Road • Juneau AK 99801

Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.tlingitandhaida.gov

Email: headstartenrollment@tingitandhaida.gov

2026-2027 Tlingit & Haida Head Start Application

SECTION A		CHILD INFORMATION	
FULL FIRST NAME:	FULL MIDDLE NAME:	FULL LAST NAME:	SUFFIX:
NICKNAME:	DOB:	Identify as: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	APPLICATION TYPE: (Choose one) <input type="checkbox"/> Early Head Start: 0-3 years old (Juneau Only) <input type="checkbox"/> Head Start preschool: 3-5 years old
IS THE CHILD OR A MEMBER OF THE HOUSEHOLD A TRIBAL CITIZEN: (Documentation required) <input type="checkbox"/> Child <input type="checkbox"/> Household member	RACE: (Choose all that apply) <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: (Choose one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Translation or Interpretation Services Needed <input type="checkbox"/> Yes <input type="checkbox"/> No	CHILD PRIMARY LANGUAGE: CHILD SECONDARY LANGUAGE:
TRIBAL AFFILIATION			
SECTION B		PRIMARY ADULT	
FIRST NAME:	LAST NAME:	DOB:	Identify as: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PRIMARY LANGUAGE:	Translation or Interpretation Services Needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
RACE: (Choose all that apply) <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: (Choose one) <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: (Check one) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Foster Parent (Attach letter) <input type="checkbox"/> Other:	HIGHEST EDUCATION LEVEL: (Check one) <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"/> Certificate:	EMPLOYMENT STATUS: <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:	Identify as: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PRIMARY LANGUAGE:	Translation or Interpretation Services Needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
RACE: (Choose all that apply) <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: (Choose one) <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: (Check one) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Foster Parent (Attach letter) <input type="checkbox"/> Other:	HIGHEST EDUCATION LEVEL: (Check one) <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"/> Certificate:	EMPLOYMENT STATUS: <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 (Attach documentation) <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? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach housing verification) Was your family referred for services by a child welfare agency? <input type="checkbox"/> Yes <input type="checkbox"/> No (Office of Children's Services, Child in Transition, ICWA, etc.)	SERVICES YOUR FAMILY RECEIVES: (Check all that apply) <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> TANF/ATAP <input type="checkbox"/> SNAP/Food Stamps <input type="checkbox"/> WIC <input type="checkbox"/> Indian Health Services (IHS) <input type="checkbox"/> None <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:** _____

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: _____ PHONE: _____ DENTIST / DENTAL CLINIC NAME: _____ 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? (while attending Head Start)	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If YES, parent/guardian will be required to fill out a separate medication authorization form prior to the first day of attendance.
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: _____

SECTION F INDIVIDUALIZED EDUCATION PROGRAM (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 IFSP or Signed Release of Information form

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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Applications will be complete when all events are received:

EHS / HS application Eligibility Documentation VacTrAK release/ Immunizations record Interview scheduled: _____



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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 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.

Form with fields for 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, be released and exchanged between Tlingit & Haida Head Start:

PROVIDE CLINIC NAMES (REQUIRED):

Form with fields for 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):

Form with fields for 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.

Form with three signature lines labeled PARENT/GUARDIAN SIGNATURE, PRINTED NAME, and DATE.

AUTHORIZATION FOR RELEASE OF IMMUNIZATION / TB RECORDS TO COMPLY WITH ALASKA'S "NO-SHOTS NO-SCHOOL" LAW

The purpose of releasing this information is to allow schools, childcare facilities and other centers that house school-age children to comply with Alaska's "No-Shots No-School" law. In many cases, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires written authorization before personal medical information can be released by a health care provider or health care organization. This form authorizes only the release of immunization records and/or confirmation of tuberculosis screening. **I understand that this does not authorize release of any other personal medical information.**

Name of child / student: _____

Date of birth: _____

Name of parent / guardian: _____

Health care provider / organization releasing information: _____

School / organization requesting information: Tlingit & Haida Head Start

Description of information to be released (check one or both):

- Immunization records
- Tuberculosis screening and results

I hereby authorize the disclosure of immunization records and / or tuberculosis screening information as described above. I understand that this authorization is voluntary. I understand that a health care provider may not condition treatment on whether I sign this authorization. I understand that if the person(s) or organization(s) authorized to receive this information is not a health plan or health care provider, the released information *may* no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may revoke this authorization at any time by notifying the organization releasing this information in writing. If I do revoke this authorization, I understand it won't affect actions taken before my revocation was received. I understand that I may request a copy of this authorization.

Please check **ONLY** one:

- I additionally authorize the re-disclosure of immunization records and/or tuberculosis screening information to other school or health care authorities should my child move to another school or school district AND I understand that this authorization to re-disclose will expire when the student reaches the age of majority or when this authorization is revoked.
- I DO NOT authorize further re-disclosure of this information and request that this authorization expire:
 - When student moves or graduates from the school or organization listed above or when this authorization is revoked.
 - Other (specify date): _____

Signature of parent or guardian: _____

Printed name of parent or guardian: _____

Today's date: _____



**HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE PROTECTED
HEALTH INFORMATION**

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 Child 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 (If Primary Physician: _____)	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: 1.800.344.1432/907.463.7127
Fax Number: 907-463-4012	Fax Number: 1.877.389.7796
Format in which you would like the recipient to receive your records: <input type="checkbox"/> Mail <input type="checkbox"/> Fax: <input type="checkbox"/> Pick Up <input type="checkbox"/> Verbal <input type="checkbox"/> Encrypted Email	

REQUIRED INFORMATION
PURPOSE OF DISCLOSURE: <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Disability <input type="checkbox"/> Law Enforcement <input checked="" type="checkbox"/> Specialist Referral <input type="checkbox"/> Attorney <input 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"/> Specialist 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 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 type="checkbox"/> Other: Head Start Physical Exam Form (Including: Growth 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)

Printed Name of Patient: _____

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 180-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 parent, guardian 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: