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@tlingitandhaida.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:* ☐ MALE ☐ FEMALE	APPLICATION TYPE: *(Choose one)* ☐ Early Head Start: *0-3 years old* ***(Juneau Only)*** ☐ Head Start preschool: *3-5 years old*

IS THE CHILD OR A MEMBER OF THE HOUSEHOLD A TRIBAL CITIZEN: *(Documentation required)*
☐ Child ☐ Household member

TRIBAL AFFILIATION

RACE: *(Choose all that apply)*
☐ Alaska Native
☐ American Indian
☐ African American/Black
☐ Caucasian/White
☐ Asian
☐ Pacific Islander/Native Hawaiian

ETHNICITY: *(Choose one)*
☐ Hispanic
☐ Non-Hispanic

Translation or Interpretation Services Needed
☐ Yes ☐ No

CHILD PRIMARY LANGUAGE:

CHILD SECONDARY LANGUAGE:

SECTION B PRIMARY ADULT

FIRST NAME:	LAST NAME:	DOB:	*Identify as:* ☐ MALE ☐ FEMALE

PRIMARY LANGUAGE:

Translation or Interpretation Services Needed ☐ Yes ☐ No

RACE: *(Choose all that apply)*
☐ Alaska Native
☐ American Indian
☐ African American/Black
☐ Caucasian/White
☐ Asian
☐ Pacific Islander/Native Hawaiian

ETHNICITY: *(Choose one)* ☐ Hispanic ☐ Non-Hispanic

MILITARY STATUS: ☐ Active ☐ Veteran

PRIMARY PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

ALTERNATE PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

E-MAIL:

RELATIONSHIP TO CHILD: *(Check one)*
☐ Parent
☐ Legal Guardian
☐ Grandparent
☐ Legal Foster Parent *(Attach letter)*
☐ Other: _____

HIGHEST EDUCATION LEVEL: *(Check one)*
☐ Highest Grade: _____
☐ High School Graduate
☐ GED
☐ Certificate: _____
☐ AA
☐ BA
☐ MA or Higher

EMPLOYMENT STATUS:
☐ FT only
☐ PT only
☐ Seasonal
☐ Training/School
☐ FT and School
☐ PT and School
☐ Retired or Disabled
☐ Unemployed

SECTION C SECONDARY ADULT

FIRST NAME:	LAST NAME:	DOB:	*Identify as:* ☐ MALE ☐ FEMALE

PRIMARY LANGUAGE:

Translation or Interpretation Services Needed ☐ Yes ☐ No

RACE: *(Choose all that apply)*
☐ Alaska Native
☐ American Indian
☐ African American/Black
☐ Caucasian/White
☐ Asian
☐ Pacific Islander/Native Hawaiian

ETHNICITY: *(Choose one)* ☐ Hispanic ☐ Non-Hispanic

MILITARY STATUS: ☐ Active ☐ Veteran

PRIMARY PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

ALTERNATE PHONE: ☐ Home ☐ Cell ☐ Work
Able to receive text messages? ☐ Yes ☐ No

E-MAIL:

RELATIONSHIP TO CHILD: *(Check one)*
☐ Parent
☐ Legal Guardian
☐ Grandparent
☐ Legal Foster Parent *(Attach letter)*
☐ Other: _____

HIGHEST EDUCATION LEVEL: *(Check one)*
☐ Highest Grade: _____
☐ High School Graduate
☐ GED
☐ Certificate: _____
☐ AA
☐ BA
☐ MA or Higher

EMPLOYMENT STATUS:
☐ FT only
☐ PT only
☐ Seasonal
☐ Training/School
☐ FT and School
☐ PT and School
☐ Retired or Disabled
☐ Unemployed

Secondary Adult Lives with Primary Parent: ☐ Yes ☐ No*
*If NO, is there a Custody Agreement? ☐ Yes *(Attach documentation)* ☐ 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)*

- ☐ Own
- ☐ Rent
- ☐ Neither

PARENTAL STATUS: *(Check one)*

- ☐ One Parent
- ☐ Two Parent
- ☐ 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? ☐ Yes ☐ No
(Attach housing verification)

Was your family referred for services by a child welfare agency? ☐ Yes ☐ No
(Office of Children's Services, Child in Transition, ICWA, etc.)

SERVICES YOUR FAMILY RECEIVES: *(Check all that apply)*

- ☐ Child Care Assistance
- ☐ SNAP/Food Stamps
- ☐ Indian Health Services (IHS)
- ☐ Supplemental Security Income
- ☐ TANF/ATAP
- ☐ WIC
- ☐ None

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
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

SECTION E CHILD HEALTH INFORMATION

PRIMARY HEALTH COVERAGE/INSURANCE:

- ☐ Denali KidCare/Medicaid
- ☐ Private
- ☐ Other: _____
- ☐ None

DOCTOR / MEDICAL CLINIC NAME: **PHONE:**

DENTIST / DENTAL CLINIC NAME: **PHONE:**

Does your child have any diagnosed food or medical allergies?	☐ Yes* ☐ No	*If YES, please explain: _____ **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.
Does your child take any medications that have to be administered during class time? *(while attending Head Start)*	☐ Yes* ☐ 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?	☐ Yes* ☐ No	*If YES, please explain: _____
Do you have any developmental concerns about your child?	☐ Yes* ☐ 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:**

Applications will be complete when all events are received:

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

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Email: headstartenrollment@tlingitandhaida.gov

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.

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):

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**

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: _____

SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH

This form is for the 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 __X__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:

____Transfer of Care ____Disability ____Law Enforcement ____Specialist
____Attorney __X__ Head Start School ____Insurance ____Other: _____

INFORMATION TO BE DISCLOSED:

____Medical records from the last two years ____Complete Designated Record Set

Date(s) of Service: ____/____/____through ____/____/____

____Health Summary ____Billing records ____Emergency room records
____Discharge summary ____Physician progress notes ____Nursing notes
____Laboratory/pathology reports ____Radiology reports ____Radiology images
____Medication list __X__Immunization record ____Accounting of disclosures
____Dental chart note ____Dental Pano X-ray ____Dental X-ray

__X__Other: ***Head Start Physical Exam Form*** (*Including: Grow measurement, Blood Pressure, Vision, Hearing, TB, Hemoglobin/Hematocrit, Physical/Developmental Assessment [ASQ], 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 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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