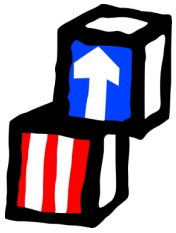
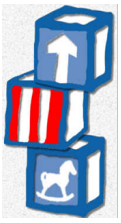
Kawerak, Inc.



Child Development Programs



Head Start/Early Head Start

Early Head Start/Child Care

Enrollment packet consists of:

- **Completed application signed and dated by a parent and a staff member.**
- **Copy of student's updated immunizations.** All immunizations and current TB screen will need to be complete before student may attend school this fall.
- **Income verification –** one of the following for the past 12 months
  - **Pay Stubs (past 12 months)**
  - **W-2s (2016) for primary and secondary applying adults**
  - **2016 Taxes**
- **Proof of Subsidy or Assistance, if applicable.**
  - **Verification Letter from SSI or Public Assistance to include the monthly amount received.**
- **Proof of birth date A copy of student's tribal enrollment or tribal eligibility verification document. One of the following.**
  - **A copy of student's tribal enrollment or tribal eligibility verification document.**
  - **Birth Certificate**
  - **Hospital Birth Record or Immunizations record.**
- **Official documents to support referrals such as OCS, Shelters, Child Care Subsidy, IEP/IFSP (educational or medical disability), or Doctor.**

****When applying for Early Head Start-Child Care Center Based programs you will also need to provide proof of current enrollment with State Child Care Assistance, or with a valid Tribal Child Care Assistance program. Contact Kawerak, Inc.'s Child Care Services Department for more information.**

All required items need to be completed and turned into Kawerak Head Start/Early Head Start by July 1st to be considered for the 2017-18 school. All others will be processed and put on waitlist for next available opening.

Kawerak Head Start/Early Head Start Staff and Kawerak Child Care Services are available to assist you with completing the application.

headstartattendance@kawerak.org P.O. Box 948, Nome, AK 99762 Phone: 1-907-443-9057
Fax: 1-907-443-9059

Kawerak, Inc.

Child Development Programs- Participant Application for Enrollment

Community (Site):	Program:	For Central Office Use: Received by:	Date Received:
	○ HS ○ EHS ○ EHS-CC ○ EHS-HB		

Applicant (child applying for services)

First Name	Middle Name	Last Name	Traditional Name	Date of Birth	Male/Female

Race	Hispanic	English Proficiency	Other Language	Other Language
□ AK Native/AM. Indian □Asian □Black □White □Hawaiin/Pac. Is. □Multi-Racial	□Yes □No	□None □Little □Moderate □Proficient		□Little □Moderate □Proficient

Private Insurance	I.H.S	Medicaid	Child's Doctor	Child's Dentist
Yes or No	Yes or No	Yes or No		

Does your child have food or medical allergies? □*Yes □No If Yes, please explain:

*"Medical Statement for Food Substitution" or other documentation, MUST be provided before we can make food substitutions.

Primary Adult

First Name	Middle	Last Name	Previous Names	Date of Birth	Male/Female

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
□ AK Native/AM. Indian □Asian □Black □White □Hawaiin/Pac. Is. □Multi-Racial	□Yes □No	□None □Little □Moderate □Proficient		□Little □Moderate □Proficient

Highest Grade COMPLETED

□ AA □BA □College Degree/ Training Cert □College or Advance Training □GED □ Grade 10 □ Grade 11 □ Grade 12 □ 9th grade or less □ High School Graduate □ Master's Degree

Employment Status

□Full Time □Part Time □Seasonal □Unemployed □Full Time & Training □Part Time & Training □Training or School □Retired or Disabled

Relationship to Child	Custody	Check all that apply:
□ Biological/Adopted/ Step □Foster □Grandchild □Other □ Other Relative	□Yes □No	□Lives with family □Provides Financial Support □Teen Parent □ Subsidized

Email Address:

Secondary Adult

First Name	Middle	Last Name	Previous Names	Date of Birth	Male/Female

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
□ AK Native/AM. Indian □Asian □Black □White □Hawaiin/Pac. Is. □Multi-Racial	□Yes □No	□None □Little □Moderate □Proficient		□Little □Moderate □Proficient

Highest Grade COMPLETED

□ AA □BA □College Degree/ Training Cert □College or Advance Training □GED □ Grade 10 □ Grade 11 □ Grade 12 □ 9th grade or less □ High School Graduate □ Master's Degree

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Relationship to Child	Custody	Check all that apply:
□ Biological/Adopted/ Step □Foster □Grandchild □Other □ Other Relative	□Yes □No	□Lives with family □Provides Financial Support □Teen Parent □ Subsidized

Email Address:

Additional children in family home financially supported by Primary/Secondary adults					
First Name	**Middle Name**	**Last Name**	**Alternative**	**Date of Birth**	**Male/Female**
First Name	**Middle Name**	**Last Name**	**Alternative**	**Date of Birth**	**Male/Female**
First Name	**Middle Name**	**Last Name**	**Alternative**	**Date of Birth**	**Male/Female**

✪ IF additional family members need to be listed then request a FAMILY MEMBER SHEET.

Family Information			
Physical Address (not PO Box)	**Mailing Address (P0 Box)**	**City**	**Zip**

Phone Numbers	Type	Note (name, primary number, etc.)
	□Cell □Home □Work □Message	
	□Cell □Home □Work □Message	
	□Cell □Home □Work □Message	

Parental Status	Primary Language at Home	Homeless***	Military Family	Referred by Child Welfare Agency	Receiving Welfare Assistance
□1 parent □2 parent		□Yes □No	□Yes □No	□Yes □No	□Yes □No

Emergency Contacts: List at least 2 contacts OTHER THAN the Primary & Secondary adults listed.				
Contact 1: Name	**Relationship**	**Telephone**	**Type** □Cell □Home □Work	
Physical Address	**City**	**Zip**	**Emergency Contact** □Yes □No	**Release Child to:** □Yes □No
Contact 2: Name	**Relationship**	**Telephone**	**Type** □Cell □Home □Work	
Physical Address	**City**	**Zip**	**Emergency Contact** □Yes □No	**Release Child to:** □Yes □No

Child's Needs
Does your child have a disability or medical condition diagnosed by a doctor or specialist? □Yes □No If YES, please clarify:
Does your child have an Individual Education Plan OR an Individual Family Service Plan? □Yes □No If YES, which program set up your IEP/IFSP?

Services or Events that have occurred within the past 12 months: (Check all that apply.)		
□ Emergency or Crisis intervention	□ Domestic violence concerns	□ OCS Intervention
□ Chemical Dependancy with in family	□ Health/Mental Health services	□ Dysfunctional or unstable living environment
□ Food Stamp	□ Military Deployment	□ WIC

Additional Information					
□ Adopted Native Child	□ Sibling currently enrolled to EHS or HS	□ Child applicant was a high risk pregnancy (EHS only)	□ Child applicant born pre-mature	□ Parent with Mental Health or Disablity issue	□ Parent Incarcerated

Previous Preschool
Has your child previously been enrolled in Head Start/Early Head Start or another preschool program? □Yes □No If yes, what program?

Documented Refferal		
□Child applicant is currently in Early Head Start and is transitioning to Head Start		
□ Professional referral (OCS, Shelter, Doctor)	□ Child Care Assistance Approved	□ Other

Please sign here to verify that you have completed this application and provided true information.		
Parent/Guardian Signature	**Printed Name**	**Date**
Intake Staff Signature	**Printed Name**	**Date**

Eligibility Determination
2017-18 School Year

Student Name	Community/School Site	Child's Date of Birth	Child's Age by Sept. 1st

Primary Adult	Secondary Adult
I work _____ hours/week for _____ months.	I work _____ hours/week for _____ months.

Total Number Supported by Income of Primary & Secondary Adults

Total Number of Children	Total Number of Adults	Is either Primary or Secondary Adult pregnant?	Total Number in Household

Additional Qualifications: All require supportive docmentation for verification

Check all circumstances that apply: □I live in a shelter. □In a motel/weekly rate housing. □Doubled-up with relatives (not by choice) □Temporary foster care placement □In an abandoned building, other inadequate accommodations, or a vehicle? If any boxes checked attach a completed Alaska Residency Form.

Is the child in foster care? □Yes □No If YES, provide OCS Documentation.

Does the family receive regular & on-going public assistance? (Temporary Assistance to Needy Families or Social Security Income) □Yes □No If YES, document reviewed:

My child has an Individual Education Plan or Individual Family Service Plan? □Yes □No
If YES, please provide a copy of IEP/IFSP with application.

Zero family income requires third party verification form

□Family income is $0.	Explanation	Applicant Signature

STOP

TO BE COMPLETED BY HEAD START STAFF

POVERTY INCOME GUIDELINES FOR ALASKA FOR 2017 (effective 1/31/17)

Household #	Annual Income Below
1	15,060
2	20,290
3	25,520
4	30,750
5	35,980
6	41,210
7	46,440
8	51,670
Each over 8	+$5,230 ea. add'l person

This family's income is:

□0-100% UNDER

□OVER income between 101% & 130%

□OVER 131% the 2017 poverty guidelines

Primary Adult	Amount (specify per hr./wk./mth)	Annual Amount	Source (check stub, W2, etc.)

Secondary Adult	Amount (specify per hr./wk./mth)	Annual Amount	Source (check stub, W2, etc.)

Income Notes	Total Annual Amount

Staff Certification

I certify that I have reviewed all information and documentation that the above calculations were completed accurately and to the best of my ability, and that the information on this form represents the family's current situation.

Signature of Staff	Printed Name	Date

2nd Staff or ERSEA Certification (calculations and documents verified)

Signature of Staff	Printed Name	Date