AVCP Head Start

Association of Village Council Presidents
Pouch 219 Bethel, Alaska 99559
907-543-7430 | Fax 907-543-5590

Enrollment Application

Dear Parent/Guardian:

Thank you for your interest in AVCP Head Start. Head Start provides free early childhood education to the qualified children agres 3 to 5, including children with disabilities.
We will need a copy of the items listed below to determine your child's eligibility, as well as an interview. **An eligibility application is required for each child you are applying for.**

Required information:
Must attach to the eligibility application, a **copy** of your child's:

☐ Immunization Record ☐ Birth Certificate ☐ IEP or IFSP (if applicable)
☐ Custody paperwork (if applicable)

You must attach income documentation (copies only) for Parents/Guardians of the household income for the past (12) twelve months.
Accepted forms of income documentation are:

☐ Current 1040 and W-2 form(s) for each working person ☐ Pay Stubs ☐ TANF Determination Letter ☐ Social Security/SSI/SSDI Determination Letter ☐ Child Support ☐ Unemployment Determination Letter ☐ Foster Care Subsity ☐ Written Statement (Only if unemployed)

When you submit your application in-person, program staff will conduct a brief interview to review your application. This process will take approximately 10 to 20 minutes, so please plan accordingly. If you are unable to drop off your application in-person, you may request a home visit or mail in the application. If you mail in the application, we will call you for a phone interview.

Your application will be sent to the central office in Bethel for determination. You will be notified by letter after we have received all of the above-requested information and your child's eligibility has been determined. Incomplete applications and failure to submit all requested information will delay the eligibility determination.

If you have any questions or need assistance, please call 1-800-478-3521 or (907) 543-7430

"AND JUSTICE FOR ALL"

In accordance with Federal law and U.S. Department of Agriculture policy. This institution is prohibited from discrimination on the basics of race, color, national origin, sex, age, disablity, and reprisal or retaliation for prior civil rights activity. (Not all prohibited bases apply to all programs). Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible State or Local Agency that administers the program or USDA's TAREGT Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information is available in languages other than English. To file a complaint of alleging discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Mail:
U.S. Department of Agriculture
Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410

Fax: (202) 690 7442; or

E-mail:
Program.intake@usda.gov

This institution is an equal opportunity provider.

Applicant

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt. ID

Race
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other :
- ☐ American Indian/Alaska Native
- ☐ Hawaiian/Pacific Islander
- ☐ Multi-Racial

Hispanic
- ☐ Yes
- ☐ No

English Proficiency
- ☐ Little
- ☐ Moderate
- ☐ None
- ☐ Proficient

Other Language Proficiency
- ☐ Little
- ☐ Moderate
- ☐ Proficient

Primary Health Coverage | Other Coverage | Insurance # | Medicaid Eligibility | Medicaid # | Doctor

Dental Coverage | Dental Coverage Number | Dentist/Dental Home

Primary/Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt. ID

Race
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other :
- ☐ American Indian/Alaska Native
- ☐ Hawaiian/Pacific Islander
- ☐ Multi-Racial

Hispanic
- ☐ Yes
- ☐ No

English Proficiency
- ☐ Little
- ☐ Moderate
- ☐ None
- ☐ Proficient

Other Language Proficiency
- ☐ Little
- ☐ Moderate
- ☐ Proficient

Highest Grade Completed
- ☐ Associate's
- ☐ Bachelor's
- ☐ Col Deg/Train
- ☐ Col or Adv Train
- ☐ GED
- ☐ Grade 10
- ☐ Grade 11
- ☐ Grade 12
- ☐ Grade 9
- ☐ HS Graduate

Employment Status
- ☐ Full Time
- ☐ Full Time & Training
- ☐ Part Time
- ☐ Part Time & Training
- ☐ Seasonal
- ☐ Training or School
- ☐ Unemployed
- ☐ Retired or Disabled

Child's Relationship
- ☐ Biological/Adopted/Step
- ☐ Grandchild
- ☐ Other Relative
- ☐ Foster
- ☐ Other

Custody
- ☐ Yes
- ☐ No

Check all that apply:
- ☐ Lives with Family
- ☐ Provides Financial Support
- ☐ Teen Parent

If teen parent, subsidized?
- ☐ Yes
- ☐ No

Email Address:

Secondary or Other Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt. ID

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- ☐ Asian
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- ☐ Other

Custody
- ☐ Yes
- ☐ No

Check all that apply:
- ☐ Lives with Family
- ☐ Provides Financial Support
- ☐ Teen Parent

If teen parent, subsidized?
- ☐ Yes
- ☐ No

Email Address:

Additional Child (Non-Applicant)

Race
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other :
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- ☐ Hawaiian/Pacific Islander
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Hispanic
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** If a family has more than one child applying for services, please complete a seperate copy of this form for each applicant.*

Applicant Name: Birthday:

Family Information

Family Living Address

Started Living At Date | Living Address | Address Line 2 | ZIP | City | State | County

Family Mailing Address

Same as living? ☐Yes ☐No | Started Using Date | Mailing Address | Address Line 2 | ZIP | City | State

Phone Number(s) | Type *(check one)* | Note *(extention or best time to call)* | Opt in for Tect Messages

_____ ☐Cell ☐Home ☐Work ☐Other ☐Yes ☐No

_____ ☐Cell ☐Home ☐Work ☐Other ☐Yes ☐No

_____ ☐Cell ☐Home ☐Work ☐Other ☐Yes ☐No

Parental Status *(check one)* ☐One ☐Two | Primary Language At Home | Homeless Family ☐Yes ☐No | Active Duty Military ☐Yes ☐No | Referred by Child Welfare Agency ☐Yes ☐No | Receiving SNAP ☐Yes ☐No | WIC ☐Yes ☐No | WIC ID *(if applicable)*

Family Income

Income verified by | Verification Date | TANF Status ☐ Yes ☐ No ☐ Formerly on TANF/Not now | SSI ☐ Yes ☐ No

Family Member	Amount	Per (example: week, month, year)	Annual Amount	Description (example: SSI, Job, Child Support)	Verification (example: W2, check stub)
_____	$ _____	_____	$_____	_____	_____
_____	$ _____	_____	$_____	_____	_____
_____	$ _____	_____	$_____	_____	_____

Income Notes:

_____

Emergency Contacts

Contact 1

Name | Relationship | Emergency Contact | Release To

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 2

Name | Relationship | Emergency Contact | Release To

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 3

Name | Relationship | Emergency Contact | Release To

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Certification: *I certify that this information is true. If any part of it is false, my participation is this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature: _____ Date: _____

AVCP HEAD START CHILD APPLICATION

List all other adults and children living in the household or children you are financially supporting

Last Name	First Name	DOB	SEX	Relationship to child

AVCP HEAD START APPLICATION

AUTHORIZATION TO EXCHANGE/RELEASE INFORMATION

FOR THE PURPOSE OF KEEPING MY CHILD'S HEALTH AND DEVELOPMENT FILES UP TO DATE, AS REQUIRED BY NATIONAL HEAD START PERFORMANCE STANDARDS, I, _____, REQUEST THAT THE INFORMATION ON MY

CHILD, _____, DATE OF BIRTH _____-_____-_____ SOCIAL SERCURITY NUMBER _____-_____-_____ BE EXCHANGED AS REQUIRED BETWEEN AVCP HEAD START AND:

YES NO

_____/_____ 1. LOCAL VILLAGE CLINIC
_____/_____ 2. BETHEL FAMILY CLINIC
_____/_____ 3. YKHC/INDIAN HEALTH SERVICES DENTAL SERVICES/MEDICAL RECORDS
_____/_____ 4. YKHC/INDIAN HEALTH SERVICES PEDIATRIC SERVICES
_____/_____ 5. YKHC WIC AND NUTRITION PROGRAMS
_____/_____ 6. YKHC MENTAL HEALTH
_____/_____ 7. _____ SCHOOL DISTRICT SPECIAL EDUCATION DEPARTMENT
_____/_____ 8. ALASKA DEPARTMENT OF PUBLIC HEALTH NURSING
_____/_____ 9. SHOULD AVCP HEAD START CONTRACT WITH PRIVATE MEDICAL AND DENTAL SERVICES PROVIDERS, I GIVE HEAD START PERMISSION TO FORWARD INFORMATION TO YKHC/INDIAN HEALTH SERVICES AND THE PUBLIC HEALTH NURSES FOR FILES AND FOLLOW UP TREATMENT.
_____/_____ 10. THE TRIABL INDIAN CHILD WELFARE, COMMUNITY FAMILY SERVICES SPECIALIST.
_____/_____ 11. OFFICE OF CHILDREN SERVICES
_____/_____ 12. OTHER _____

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**

_____
COMMUNITY

_____ _____
WITNESS SIGNATURE **DATE**

_____
WITNESS SIGNATURE

AVCP HEAD START

VERIFICATION FOR HOMELESSNESS

This is to verify with the AVCP Head Start staff that we are considered homeless because we are living with other family members and do not own our own home. If there should be any changes in our circumstances we will notify the local Head Start Staff.

Date: _____

Child's Name: _____

_____ _____

(parent signature) (parent signature)

_____ _____

(print parent name) (print parent name)

_____ _____

(staff signature) (print staff name)

Revised 8/15/19

AVCP HEAD START

INCOME VERIFICATION FOR UNEMPLOYMENT

This will serve as a verification form that I [or both parents] are unemployed and have no income. I also agreed if there should be any changes in my income status I will notify the AVCP Head Start staff and as long as my child is enrolled in the program.

Date: _____

Child's Name: _____

_____ (parent signature)

_____ (parent signature)

_____ (print parent name)

_____ (print parent name)

_____ (staff signature)

_____ (print staff name)

Revised 8/15/19

AVCP HEAD START

Head Start Eligibility Verification

I/We are requesting that AVCP TANF ASSISTANCE program release my/our income for the purpose of establishing my child[s] entry into the AVCP Head Start program.

TANF CASE # _____

ANNUAL TANF INCOME: _____

SOCIAL SECURITY: _____-_____-_____

Parent/Guardian Signature

_____ Date: _____

Printed Name: _____

Village: _____

To be filled out by TANF

I, verify that _____ is receiving TANF Assistance.

Case Worker Signature: _____ Date: _____

Printed Name: _____

Revised 8/15/19