ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS

Thaddeus Tikiun Jr., Chairperson | Vivian Korthuis, CEO | AVCP.org

Youth & Child Unit

1200 State Highway, PO Box 219, Bethel, AK 99559

Youth & Child Unit

Head Start Description of Services

Through Head Start, children are prepared for grade school by providing nurturing learning environment that meets the emotional, social, health, nutritional, and psychological needs of its students. Head Start also emphasizes the role of parents as their child's first and most important teacher.

Services are available for children who are 3-5 years old.

Child Care Description of Services

The AVCP's Child Care Program provides a unique solution to address the challenges of finding and paying for child care by providing both financial assistance to tribal members, and also by providing employment opportunities for child care providers.

Services are available for children who are 12 years old or younger. ***Children who have special needs and require additional assistance, are eligible for care up to the age of 19.***

Submit Your Applications

- Nearest/Local TWD Navigator
- Local Head Start Center/Home Base
- Local Child Care Specialist

Or Mail to
Youth & Child Unit
PO Box 219
Bethel, AK 99559
Head Start Email – Headstartco@AVCP.org Fax 907-543-5590
Child Care Email – Bethelchildcare@AVCP.org Fax (907) 543-4261

Child Care

Central office (907) 543-8701

Village Office Locations

- Aniak
- Eek
- Emmonak
- Hooper Bay
- Kasigluk
- Kwigillingok
- Napaskiak
- St. Mary's
- Toksook Bay

Head Start

Central office (907) 543-8720

Village Locations

Center-Based

- Akiachak
- Bethel
- Chefornak
- Quinhagak
- Russian Mission
- Tuluksak

Home-Based

- Akiachak
- Scammon Bay
- Tuntutuliak
- Kotlik

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Youth and Child Unit
P.O. Box 219
Bethel, Alaska 99559
Child Care Email: bethelchildcare@avcp.org
Head Start Email: Headstartco@avcp.org

Youth & Child Unit Parent/Guardian Application

This application will be used to determine eligibility for all youth and child unit programing to include Head Start services, Child Care, and other services as applicable. Please complete the entire application and attach ALL required documents listed below or requested by staff BEFORE submitting, incomplete applications may take longer to process.

1. **What service(s) are you requesting?** Child Care ☐ and/or Head Start ☐

□ **Child Care** in my home	□ **Head Start services** at a Head Start center (if available in the community)
□ **Child Care** in my child care provider's home	□ **Head Start services** at my home (weekly home visit for parent/child school-readiness if available in the community)

2. **Are you receiving Cash Assistance?** Yes ☐ No ☐
   Which one: ☐ TANF ☐ General Assistance ☐ SNAP or ☐ Other _____

3. **List all child(ren) needing Child Care and/or Head Start services and which service you are requesting for each:**

First Name	*M.I*	*Last Name*	*Date of Birth (mm/dd/yy)*	*Age*	*Gender*	*School hours (if attending)*	*Child is in State or Tribal Custody*	*Head Start, Child Care or both?*

4. **CHILD CARE SERVICES** The following documents are required for these services:
   ☐ Completed application
   ☐ 2 Releases of Information - (Public Health and AVCP Services)
   ☐ Proof of Tribal Membership of child(ren) - (Navigator or AVCP staff observed either tribal ID or verified enrollment for each child OR Navigator or AVCP staff observed parent ID in lieu of child(ren)If ID viewed by staff and not attached include CIB or enrollment number: _____
   Staff member verifying Membership _____ Date _____
   ☐ Income Verification* (Income of child's parent(s) living in the home – Only attach if there is a waiting list for

services. - Prior 1 month's pay stubs, or most recent federal tax forms) *** NOT NECESSARY IF PARENTS CURRENTLY RECEIVE TANF, GENERAL ASSISTANCE, OR SNAP BENEFITS.**

☐ Qualifying Activity Verification: Employment Verification Form; school/training acceptance and/or schedule with parent/guardian name; self-employment certification; subsistence certification; verified children in OCS/protective services.

5. Have you selected a Child Care Provider?** If yes, Provider's name: _____
My provider is a relative: Yes ☐ No ☐

****Siblings of children living in the same home as the children are *not* eligible to be a child care provider.**

Providers must complete a *Provider Application*, pass a *Criminal Background Check*, and receive *Provider Training*.

6. **HEADSTART SERVICES** The following documents are required for these services:

☐ Complete application

☐ Releases of Information - (Public Health and AVCP Services)

☐ Proof of Tribal Membership of child(ren) if applicable - (Navigator or AVCP staff observed either tribal ID or verified enrollment for each child OR Navigator or AVCP staff observed parent ID in lieu of child(ren)If ID viewed by staff and not attached include CIB or enrollment number: _____
Staff member verifying Membership _____ Date _____

☐ Income Verification*- (Income of child's parent living in the home - the last 12 month's pay stubs, work statement, or most recent federal tax forms. **THIS IS NOT NECESSARY IF PARENTS ARE CURRENTLY RECEIVING TANF, GENERAL ASSISTANCE, SNAP or SUPPLIMENTAL SECURITY INCOME** (SSI) **BENEFITS.**

☐ Proof of SSI and SNAP (if applicable)

PART A. APPLICATION INFORMATION

Parent/Guardian 1:	Parent/Guardian 2 (if living in the same home):
Parent/Guardian 1 Date of Birth:	Parent Guardian 2 Date of Birth:
Telephone Number:	Telephone Number:
Email address:	Email address:
PO Box:	Street Address:
City, State, Zip Code:	

1. Is the parent and/or child(ren) a Tribal Member? Yes ☐ No ☐
   If yes, which Tribe: _____
2. Do you own your own home? Yes ☐ No ☐
3. Do you rent a home? Yes ☐ No ☐ If yes, name of Landlord_____
4. Do you live in a family member's or other person's home? Yes ☐ No ☐

PART B. FAMILY INFORMATION

1. Are any of the child(ren) you are applying for:

   ☐ Suspected of having a developmental delay, physical, or mental disability; OR

   ☐ Has been referred for or diagnosed as having a mental or physical disability.

   If yes, list child's name and DOB _____

Please provide documentation of disability diagnosis. (Children with documented disabilities are eligible for child care services up to age 19.)

2. Children in certain family situations receive priority for services. Please check all that apply to your family:

   ☐ *The Child(ren) has an incarcerated parent*

   ☐ *The Child(ren) is in foster care or relative placement*

   ☐ *I am a Single Parent*

   ☐ *We are experiencing/struggling with - domestic violence, drugs/alcohol abuse, mental illness, a death in the family, or something else. Please explain:* _____

Please list all other family members in your home:

First Name	Last Name	Date of Birth (mm/dd/yy)	Relationship to Parent/Client

PART C. EMPLOYMENT/EDUCATION INFORMATION

If this is an application for Child Care services, please consider the hours of child care that you need. This information will be used to determine the number of child care hours you are approved for.

□ Parent 1 is unemployed

□ Parent 2 is unemployed

EMPLOYMENT (IF SELF-EMPLOYED FILL OUT THE CERTIFICATION BELOW)

Parent/Guardian Name	Place of Employment (If self-employed sign statement below)	Salary/hourly wage	Total number of hours worked each week	Workdays (M, T, W, Th, Fr, Sa, Su)	Daily Start/End time	On Call Yes or No
1.						
2.						

SCHOOL/TRAINING

Parent/Guardian Name	Name of School/Training Program	Days attending /Part time/ Full time	Daily Start/End time
1.			
2.			

SELF-EMPLOYMENT CERTIFICATION

I _____ (name of parent/guardian), do certify that I am self-employed. My work is (please describe your work) _____.

My hourly rate or fee per service or good is _____. I work an average of _____ hours per week.

My annual income was _____.

SUBSISTENCE HUNTING/FISHING/GATHERING

AVCP pays for child care services for one (1) parent/guardian per household who is a subsistence provider part-time. The following is a list of activities that qualify as subsistence activities including but not limited to: hunting, fishing, berry-picking, gathering of eggs, shoots, greens, and other vegetation, cutting fish, preparing meat, hauling wood, packing water, building, maintaining, and repairing subsistence equipment and structures used for food preparation and storage.

If one parent/guardian wishes to apply for child care hours to enable them to perform subsistence activities, please fill out the certification below. (Note if a 2 parent/guardian home, only 1 parent can qualify for subsistence child care hours, the other parent must have other approved activities in order for the family to qualify for services.)

SUBSISTENCE CERTIFICATION (CANNOT BE APPROVED FOR MORE THAN FULL TIME CHILD CARE ASSISTANCE SCHEDULE or PART TIME IN A 2 PARENT FAMILY)

I _____ (name of parent/guardian), do certify that I provide subsistence. I am allowed up to 5 hours of subsistence per day, up to 5 days a week. On average I provide subsistence activities ___ number of days per week. If I require additional temporary hours of subsistence I will contact the Bethel Child Care Office in advance.

I hereby certify that the information provided herewith is true, correct, and complete to the best of my knowledge. I acknowledge that this information will be relied upon to determine my eligibility for Child Care Assistance and/or Head Start.

_____ _____

Signature of Parent/Guardian 1 Date

_____

Printed Name

_____ _____

Signature of Parent/Guardian 2 Date

_____

Printed Name

The below certifications require signatures for Child Care Participants Only

SCHEDULE AND NOTIFICATION OF CHANGES:

I understand that the information I provided regarding work, school/training and subsistence work will determine the time that my child(ren) are eligible to receive child care services.

If there is a need for a temporary change (less than 1 month) to the schedule, approval must be requested in advance by contacting the Bethel Youth & Child Unit. If circumstances change and I require permanent (more than 1 month) changes to the above-approved schedule, I must notify the Youth & Child Unit's Childcare Program at least ***14 days in advance*** and supply all necessary verification documents. After the changes have been approved, a new Letter of Certification will be mailed to me. If I **fail to give proper notice I may have to pay my Child Care Provider(s) for the child care services that they provided during that time.**

CHILD CARE CERTIFICATION STATEMENT

I (we) agree to:

1. Pay my provider for any days of care exceeding the approved days.
2. Notify AVCP before changing providers.
3. Notify AVCP immediately when changes occur to:
    - employment and/or school enrollment (i.e. job loss or school ending);
    - address and/or phone numbers;
    - I needs more hours of child care, or if child care is no longer needed.
4. Certify my provider's time sheet at the end of each month.

I hereby certify that the information provided herewith is true, correct, and complete to the best of my knowledge. I acknowledge that this information will be relied upon to determine my eligibility for Child Care Assistance and understand that if I provide false or misleading information, my child care assistance will be immediately terminated or denied, and I will be responsible for any unpaid child care hours.

I understand that Child Care services may be canceled by the Child Care Provider or AVCP without cause, by giving thirty (30) days notice of intent to cancel. I also understand that AVCP reserves the right to terminate any child care arrangement if necessary to protect the health, safety, and development of the child(ren) or as otherwise determined by AVCP at its sole discretion. If I disagree with AVCP's decision to terminate the child care arrangement I may request a Fair Hearing under AVCP's Fair Hearing Policy.

_____ _____

Signature of Parent/Guardian 1 Date

_____ _____

Signature of Parent/Guardian 2 Date

DISCLAIMER OF LIABILITY

I (we) acknowledge and understand that my(our) Child Care Provider is not an employee of AVCP and AVCP does not assume any responsibility for the services or care provided by them. I (we) hereby fully and forever release and discharge AVCP from, and expressly waive, any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, that may arise from or as a result of my(our) Child Care Provider's performance. I (we) agree not to make or bring any such claim or demand against AVCP, and fully and forever release and discharge AVCP from liability under such claims or demands.

_____ _____

Signature of Parent/Guardian 1 Date

_____ _____

Signature of Parent/Guardian 2 Date

AVCP YOUTH & CHILD UNIT
CHILD CARE PARENT EMPLOYMENT VERIFICATION FORM

I have applied for child care services through AVCP. My signature below authorizes release of the information.
The employment information is listed below. AVCP will only use this information for purposes of eligibility.

_____

Parent Name Signature Date

To Be Filled Out by Employer:

The above-named individual has applied for services through the AVCP Child Care Department.
Please provide the following information for verification.

Employer Name: _____ Address: _____

Phone Number: _____ Fax No: _____

Applicant Job Title: _____ Start Date: _____

Please check days the employee works

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Work Hours: Starting Time: _____ a.m./ p.m. End Time: _____ a.m./p.m.

Average number of hours worked per week _____

Does this employee work on call? ☐ Yes ☐ No

If yes, estimated number of days in a month the employee is called in to work: _____

Please provide further information about on call employment

_____

_____

Hourly Wages: _____

Paid: □ Weekly □ Bi-Weekly □ Twice a Month □ Monthly

Supervisor's Name: _____ Title: _____

Supervisor signature: _____ Date: _____

Immunization Record Request Form

All immunization record requests must be accompanied by a copy of documentation that identifies the person requesting the immunization record. Examples of acceptable forms of identification are: a state-issued photo driver's license with address, a state-issued photo identification card with address or a U.S. passport or passport card with photo. **Please verify that the copy of the identification cards is legible, please enlarge copy if needed.**

If you need to request multiple records, please submit an Immunization Records Request Form for each record. If the record requested is for a minor under 18 years of age, please state your relationship to the minor in the "Requestor's Relationship" field. If you are requesting records for someone under 18 years of age, their records will be only released to a school or daycare facility.

Immunization record requests will be processed within 5-7 business days.

IMMUNIZATION RECORD REQUESTED FOR:			
First Name:	**Middle Name:**	**Last Name:**	
Date of Birth: Month / Day / Year	**Gender:**	**Phone Number:**	**Previous Name:**
Current address:	**City:**	**State:**	**Zip:**

REQUESTOR'S INFORMATION (PERSON REQUESTING RECORD)			
Requestor's Name:	**Requestor's Relationship:** Select		
Current address:	**City:**	**State:**	**Zip:**
Phone:	**E-mail:**		

By signing this agreement, I_____**hereby authorize the Alaska Department of Health (DOH) to release immunization information that may be held by the Alaska Immunization Information System (VacTrAK) of the Alaska Department of Health. I authorize release in the manner that I have requested. This information is to be released and sent to the following:**

(print name of requestor)

☐ **School** ☐ **Daycare/Childcare center** ☐ **Self** (Records will be sent to you only if it is your record and you are over 18 years of age)

Recipient/To the Attention of:	**Name of Organization:**
Fax record to fax number:	**Phone number:**
Address of School or Daycare/Childcare center:	
Requestor's Signature:	**Date:**

Once this form is completed, please print, sign and date. Send form along with a copy of supporting documents to VacTrAK via Fax or Mail.

Fax: **907-562-7802 ATTN: VacTrAK Records Request**

Mail: **Alaska Department of Health**
Division of Public Health, Section of Epidemiology
Alaska Immunization Program-VacTrAK
3601 C Street, Suite 540
Anchorage, AK 99503

If your records are found in our system, we will send the records to the destination you requested above.If your records are not found in our system, we will contact you. VacTrAK may reach out to you via email for additional information on your request. **VacTrAK will not be able to process emailed vaccine record request or send vaccine records via email.**

Association of Village Council Presidents (AVCP)
P.O. Box 219
Bethel, Alaska 99559

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, (name of parent/guardian) hereby authorize the release and exchange of my personal and protected information as well as that of my child(ren):

Child name	**Date of Birth**
Child name	**Date of Birth**
Child Name	**Date of Birth**

This release includes the following information: □Birth Certification □ Social Security Number

□ Verification of Tribal Enrollment □ Employment Pay Stubs □Verification of Selective Service

□ Verification of Employment □ Verification of Residency □Verification of Public Assistance/ SOA Unemployment

□Verification of Education Diploma, Degree, or Certificate □ Verification of Income □ Verification of Disability Status

□Other:_____

This information will be disclosed between programs within AVCP as necessary for the sole purpose of determining my eligibility, or continued eligibility, for benefits and services provided by AVCP. This release specifically authorizes the exchange of my personal and protected information between AVCP's programs, including but not limited to, the AVCP Benefits Division, Tribal Workforce Development Program and programs in the Youth & Child Unit, along with any other AVCP program. This release also authorizes AVCP to input personal information from my child(ren)'s Youth & Child Unit application into the Child Plus database, a third party service provider that supports AVCP's initial and ongoing eligibility determination, educational performance tracking, and grant reporting to the HeadStart and 477 Child Care grantees.

I understand that this authorization is voluntary. I also understand that my records may contain sensitive information. To the extent that this information is required to remain confidential by federal or state law, the department or program receiving my personal protected information will continue to keep this information confidential. I understand that I may request a copy of this signed authorization at any time. This authorization expires two years from the date of signature unless I choose to revoke it sooner. If I choose to revoke this authorization before its expiration, I will notify AVCP of the revocation in writing.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____
Signature of Applicant	**Date**
_____	_____
Print Name	**Date of Birth**
_____	_____
IF UNDER 17 Years of Age: Signature of Parent or Guardian	**Date**