Kenaitze Kuya Qyut 'anen Early Childhood Center

130 N. Willow St Kenai, AK 99611 Phone (907) 335-7260 Fax (907)283-5898
Website: www.kenaitze.org

Enrollment Application

INSTRUCTION SHEET FOR ENROLLMENT APPLICATION

This page is to help you fill out the application, when the application is completed please send back to Kenaitze Kuya Qyut'anen Early Childhood Center at 130 North Willow Street in Kenai. Applications will not be processed until all required information is returned.

CHILD'S NAME:
Please use child's legal name as it appears on the birth certificate.

BIRTH CERTIFICATE:
Proof of birth date (copy of birth certificate) is required and must be attached.

IMMUNIZATIONS:
A copy of your child's current immunization record must be attached.

INCOME:

A. Income must be current. **A child that is homeless, from a family that is receiving public assistance, or a child in foster care is eligible even if the family income exceeds the income guidelines.**

B. All income must be verified. The following are acceptable for income verification.
- Wages for the immediately previous 12 months can be verified with pay stubs (with company name clearly printed on stub) or a letter from your employer written on company letterhead.
- Wages for the previous calendar year can be verified with W2's or the previous year's income tax return.
- Alaska Permanent Fund Dividends are counted.
- Social Security and SSI can be verified with an award letter.
- Unemployment can be verified with a printout of payments from the Employment Division, Income Tax or 1099-G.
- For foster children, a written letter from caseworker can be used for verification.
- For verification of public assistance, written documentation is required.

HOMELESS:
The term 'homeless children and youth' means individuals who lack a fixed, regular, and adequate nighttime residence. KIT ECC staff will assist in this determination with an additional Housing Questionnaire.

ALASKA NATIVE/AMERICAN INDIAN ELIGIBILTY:
The following can be used to verify Alaska Native/American Indian eligibility:
- Certificate of Indian Blood
- Tribal Enrollment Card
- Letter of Tribal enrollment written by Tribal Enrollment Coordinator
- Any of the above in the parent's name can be used for verification (as long as parents name appears on the child's birth certificate).

We must be able to reach you in order to enroll your child. If you move or change your phone number it is your responsibility to notify our office at 335-7260 as soon as possible.

THANK YOU FOR YOUR INTEREST IN OUR PROGRAM!

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ELIGIBILITY APPLICATION
School Year: 2016-2017

APPLICANT/CHILD INFORMATION			
First Name:	**Middle Initial:**	**Last Name:**	**Nickname:**
Ethnicity: Hispanic or Latino origin ☐ Yes ☐ No	**Date of Birth:**	**Gender:** ☐ Male ☐ Female	
	Race (check one): ☐ American Indian/Alaska Native ☐ Asian ☐ Biracial/Multi-Racial ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other		
Primary Language:		**Secondary Language:**	
Disabilities:	Does this child have a suspected disability or special need? ☐ Suspected ☐ No Does this child have a current IEP/IFSP from an Agency or School District? ☐ Yes ☐ No If yes, what Agency or School District? ______________________________________		
Child Care Name:	**Address:**	**Phone:**	

Family Type: ☐ One Parent ☐ Two Parents — **PRIMARY PARENT/GUARDIAN**			
First Name:	**Last Name:**	**Date of Birth:**	**Gender:** ☐ M ☐ F
Physical Address:	**Mailing Address:**	**City/State**	**Zip:**
Email Address:	**Home Phone:**	**Cell Phone:**	**Message Phone:**
Relationship to Child:	☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Foster Parent ☐ Grandparent ☐ Legal Guardian		
Education:	☐ 9 or below ☐10 ☐ 11 ☐ High School Graduate/GED ☐ Some College/Vocational School ☐ Bachelor's or advanced degree		
Ethnicity: Hispanic or Latino origin ☐ Yes ☐ No	**Race (check one):** ☐ American Indian/Alaska Native ☐ Asian ☐ Biracial/Multi-Racial ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other		
	Primary Language:	**Secondary Language:**	
Employment Status:	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Training or in school ☐ Seasonally Employed-(how many months a year)_____ ☐ Self-Employed ☐ Retired or Disabled **Provides Financially for Child** ___Yes ___No **Occupation:** ________________________		
Employer Name:	**Address:**	**Phone:**	

SECONDARY PARENT/GUARDIAN			
First Name:	**Last Name:**	**Date of Birth:**	**Gender:** ☐ M ☐ F
Physical Address:	**Mailing Address:**	**City/State**	**Zip:**
Email Address:	**Home Phone:**	**Cell Phone:**	**Message Phone:**
Relationship to Child:	☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐ Foster Parent ☐ Grandparent ☐ Legal Guardian		
Education:	☐ 11th or below ☐ High School Graduate/GED ☐ Some College/Vocational School ☐ Bachelor's or advanced degree		
Ethnicity: Hispanic or Latino origin ☐ Yes ☐ No	**Race (check one):** ☐ American Indian/Alaska Native ☐ Asian ☐ Biracial/Multi-Racial ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other		
	Primary Language:	**Secondary Language:**	
Employment Status:	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Training or in school ☐ Seasonally Employed-(how months a year) _____ ☐ Self-Employed ☐ Retired or Disabled **Provides Financially for Child** ___Yes ___No **Occupation:** ________________________		
Employer Name:	**Address:**	**Phone:**	

FAMILY INFORMATION					
Total Number in Family:			**Number of Children in Family:**		
First Name:	**Middle Name:**	**Last Name:**	**Birth date:**	**Gender**	**Relationship to Applicant/Child:**

Is anyone in the household pregnant? □ Yes □ No If yes, estimated due date? _______________

How did you learn about Head Start: □ Family/Friend □ Radio/Newspaper □ Website □ Fliers □ Other__________

Have you had any other children attend Kenaitze Indian Tribe's Head Start? Name:___________________________

Is your family currently receiving ATAP/TANF benefits? ....□ Yes □ No

Are you or anyone in your family currently receiving Supplemental Security Income (SSI)? ....□ Yes □ No

Are you or anyone in your family currently receiving WIC? ....□ Yes □ No

Are you or anyone in your family currently receiving Food Stamps (SNAP)?...□ Yes □ No

Is this child a foster child placed with you through the State of Alaska, Office of Children Services, or Tribal Court? ....□ Yes □ No

Has either parent ever been a part of the United States Military?.. □ Yes □ No

If yes, what branch?__________________

which parent? ____________________

Vetran or non-vetran?__________

Is either parent currently on active duty?... □ Yes □ No

Check all that apply: □ No Insurance □ Medicaid □ Denali Kid Care □ IHS □ Private

□ Yes □ No Homeless status?

□ Yes □ No Are you currently doubled up with another family due to housing expenses?

□ Yes □ No Are you living in temporary housing, motel or shelter?

The term homeless means individuals who lack a fixed, regular and adequate nighttime residence. This includes children and youths who are sharing the housing of other person due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, poor quality trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement.

Applications are given priority for certain child and family needs, examples include homelessness, need for food, family separation or divorce, domestic violence history, English as a second language, child or family with disabilities, poor living conditions, or death in immediate family. Please list your child/family needs or concerns:

I swear (or certify) that I am the parent or legal guardian of the child applying for Head Start, and that, to the best of my knowledge, all of the information that I have provided is complete and correct.

______________________________________ ______________________________

Parent/Guardian Signature **Date**

______________________________________ ______________________________

Receiving Staff Signature **Date**

This application is valid for 6 months.

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CHILD'S PHYSICAL EXAM – (To be filled out by Medical Provider)

Child's Name: ____ DOB: __________________

Physical Exam	Normal	Finding	Screening	Result
1. General Appearance			• Height	
2. Review of Health History			• Weight	
3. Nose/Throat/Mouth/Teeth				
4. Eyes/Ears			• Blood Pressure	
5. Glands (Lymph/Thyroid)			• Hemoglobin or Hematocrit	
6. Lungs/Heart				
7. Abdomen			• Vision – Both eyes	
8. Bones/Joints/Muscles			Right eye	
9. Skin			Left eye	
10. Neurological/Development			• Strabismus	
• Gross/Fine Motor Skills				
• Cognitive Skills			• Hearing – Both ears	
• Social/Self-help Skills			Right ear	
• Speech/Communication			Left Ear	
			• TB Test- Date given **(required upon enrolling)**	
			Date read	
			• Lead Level Screen **(required upon enrolling)**	

11. Has the child ever been diagnosed with any of the following conditions? (Please circle those that apply)

Asthma	**Vision Problems**
Anemia	**High Lead Level**
Hearing Difficulty	**Diabetes**
Overweight	**Other:(Explain)**

Question	Answer	
1. Is the child on any medication now?	[ ]No [ ]Yes	
2. Are the child's immunizations up to date?	[ ]No [ ]Yes	
3. Is the child able to participate in usual school activities?	[ ]No [ ]Yes	

Medical Provider Signature:____ Date: __________________

Medical Center/Clinic: ____

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HEMOGLOBIN RESULTS (required yearly)

_______________________________ received an Hg test on ____________________
NAME DATE

The results were: ______________________

______________________________ ____________________
Signature of Health Care Provider DATE

Address: ______________________________ Phone: ____________________
______________________________ Fax: ____________________
____

TB SCREENING RESULTS (required 1st year only)

_______________________________ received PPD test on ____________________
NAME DATE

It was read on ________________
DATE

The results were: ______________________
Positive __________________ mm Negative ____________________

______________________________ ____________________
Signature of Health Care Provider DATE

Address: ______________________________ Phone: ____________________
______________________________ Fax: ____________________
____