



Community: _____

Program Applying For: Check One		
<input type="checkbox"/> Head Start	<input type="checkbox"/> Parents as Teachers	<input type="checkbox"/> DHSS
<input type="checkbox"/> Early Head Start	<input type="checkbox"/> Child Development Center	<input type="checkbox"/> YK Strengthening Families

SECTION A CHILD INFORMATION			
FULL FIRST NAME:	FULL MIDDLE NAME:	FULL LAST NAME:	SUFFIX:
NICKNAME:	DOB:	SOCIAL SECURITY NUMBER: (Optional)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER
RACE: (Choose all that apply) <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian	ETHNICITY: (Choose one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	CHILD PRIMARY LANGUAGE: _____ <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	CHILD SECONDARY LANGUAGE: _____ <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient
Is the child transitioning from:	<input type="checkbox"/> EHS	<input type="checkbox"/> PAT	

SECTION B PRIMARY ADULT			
FIRST NAME:	LAST NAME:	DOB:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER
PRIMARY LANGUAGE:	Translation or Interpretation Services Needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
RACE: (Choose all that apply) <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian	ETHNICITY: (Choose one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	MILITARY STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Veteran	
	PRIMARY PHONE: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Do you want to receive text messages on this phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	ALTERNATE PHONE: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Do you want to receive text messages on this phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E-MAIL: _____			
RELATIONSHIP TO CHILD: (Check one) <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Foster Parent (Attach letter) <input type="checkbox"/> Other: _____	HIGHEST EDUCATION LEVEL: (Check one) <input type="checkbox"/> Highest Grade: _____ <input type="checkbox"/> AA <input type="checkbox"/> High School Graduate <input type="checkbox"/> BA <input type="checkbox"/> GED <input type="checkbox"/> MA <input type="checkbox"/> COL	EMPLOYMENT STATUS: (Check one) <input type="checkbox"/> FT only <input type="checkbox"/> FT and School <input type="checkbox"/> PT only <input type="checkbox"/> PT and School <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training/School <input type="checkbox"/> Unemployed	

SECTION C SECONDARY ADULT			
FIRST NAME:	LAST NAME:	DOB:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER
PRIMARY LANGUAGE:	Translation or Interpretation Services Needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
RACE: (Choose all that apply) <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian	ETHNICITY: (Choose one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	MILITARY STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Veteran	
	PRIMARY PHONE: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Do you want to receive text messages on this phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	ALTERNATE PHONE: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Do you want to receive text messages on this phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E-MAIL: _____			
RELATIONSHIP TO CHILD: (Check one) <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Foster Parent (Attach letter) <input type="checkbox"/> Other: _____	HIGHEST EDUCATION LEVEL: (Check one) <input type="checkbox"/> Highest Grade: _____ <input type="checkbox"/> AA <input type="checkbox"/> High School Graduate <input type="checkbox"/> BA <input type="checkbox"/> GED <input type="checkbox"/> MA <input type="checkbox"/> COL	EMPLOYMENT STATUS: (Check one) <input type="checkbox"/> FT only <input type="checkbox"/> FT and School <input type="checkbox"/> PT only <input type="checkbox"/> PT and School <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Training/School <input type="checkbox"/> Unemployed	
Secondary Adult Lives with Primary Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No*			
*If NO, is there a Custody Agreement? <input type="checkbox"/> Yes (Attach documentation) <input type="checkbox"/> 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.

CHILD'S NAME: _____ DOB: _____ COMMUNITY: _____

SECTION D FAMILY INFORMATION			
LIVING ADDRESS: Address: _____ City: _____, AK Zip _____		MAILING ADDRESS: Address: _____ City: _____, AK Zip _____	
HOUSING: (Check one) <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Neither			
PARENTAL STATUS: (Check one) <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent <input type="checkbox"/> 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? (If YES, attach housing form) <input type="checkbox"/> Yes <input type="checkbox"/> No	Was your family referred for services by a child welfare agency? (Office of Children's Services, Child in Transition, ICWA, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	SERVICES YOUR FAMILY RECEIVES: (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Child Care Assistance <input type="checkbox"/> SNAP/Food Stamps <input type="checkbox"/> WIC <input type="checkbox"/> Indian Health Services (IHS) <input type="checkbox"/> TANF/ATAP <input type="checkbox"/> Supplemental Security Income
Does your family have reliable transportation? (Head Start Only) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of individuals related by blood, marriage or adoption, living in the home, supported by the <u>parent/guardian's</u> income: NUMBER OF ADULTS: _____ NUMBER OF CHILDREN: _____ TOTAL NUMBER: _____			

SECTION E CHILD HEALTH INFORMATION	
PRIMARY HEALTH COVERAGE/INSURANCE: <input type="checkbox"/> Denali KidCare/Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Other: _____ <input type="checkbox"/> None	DOCTOR/MEDICAL CLINIC NAME: _____ PHONE: _____ DENTIST/DENTAL CLINIC NAME: _____ PHONE: _____
Does your child have any diagnosed food or medical allergies? <input type="checkbox"/> Yes* <input type="checkbox"/> No If YES, please explain: <i>*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.</i>	Does your child take any medications that have to be administered during class time? (Head Start Only) <input type="checkbox"/> Yes* <input type="checkbox"/> No <i>*If YES, parent/guardian will be required to fill out a separate medication authorization form.</i>
Do you have any health concerns about your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain:	Do you have any developmental concerns about your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain:
Is your child potty trained? (Head Start Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION F CHILD INDIVIDUALIZED EDUCATION PLAN (IEP)/ INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)	
Is your child currently being evaluated for an IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child have a current or expired IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please attach copies of the: <input type="checkbox"/> IEP <u>or</u> <input type="checkbox"/> IFSP <u>or</u> <input type="checkbox"/> 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 RurAL CAP. I agree to review this information every year. I agree to allow RurAL CAP to share my child's information within RurAL CAP's early childhood programs. All information is kept strictly confidential and I may access it during normal business hours.	
PARENT/GUARDIAN SIGNATURE: _____	DATE: _____
RURAL CAP SITE STAFF SIGNATURE: _____	DATE: _____

CENTRAL OFFICE STAFF USE ONLY							
INCOME VERIFICATION: <input type="checkbox"/> Income Tax Form <input type="checkbox"/> W-2 <input type="checkbox"/> TANF/ATAP <input type="checkbox"/> Pay Stubs <input type="checkbox"/> Unemployment Statements <input type="checkbox"/> Adult PFD <input type="checkbox"/> SSI <input type="checkbox"/> Foster Care Reimbursement <input type="checkbox"/> No Income Statement <input type="checkbox"/> Other: _____							
PRIORITY	<i>Income</i>	<i>Parent Status</i>	<i>Age</i>	<i>Transition</i>	<i>Disability</i>	<i>Other/OCS</i>	TOTAL POINTS
CODE							
POINTS							
CONCERN STATUS	PRIMARY CONDITION	IEP/IFSP DATE	ED/DIS INITIALS	ALLERGY		FS INITIALS	
IMMUNIZATIONS:	<input type="checkbox"/> Complete <input type="checkbox"/> Needs <input type="checkbox"/> Exempt <input type="checkbox"/> Up-to-Date		CDC ONLY				
TOTAL ANNUAL INCOME	ENROLL STATUS	CLASSROOM	Classroom:	BB C D O Class: Toddler Preschool School Age			
\$	<input type="checkbox"/> Accept <input type="checkbox"/> Waitlist	C D E H I J V	Tuition:	A B C	Sibling Discount:	Yes No CCA: Pass I Pass II/III CITC OCS Self-Pay	
STAFF NAME:	STAFF SIGNATURE:		Effective Date:				
ELIGIBILITY DATE:							

