



## KIOWA TRIBE HEAD START PROGRAM

### ENROLLMENT APPLICATION

#### Information Sheet



The Kiowa Tribe Head Start Program provides pre-school and comprehensive social services to eligible low-income 3, 4 and 5 year old children and their families at no cost. **Children must be 3 years of age by September 1st in the Program year for which you are applying.**

All parents/guardians will receive a multi-page enrollment application that contains the following documents:

1. **Confidentiality Policy**
2. **Kiowa Tribe Head Start Application**
3. **Authorization to Release Information** (This gives the Kiowa Tribe Head Start Program permission to acquire necessary information needed to complete your child's file.)\*
4. **Consent for Health Services Form**
5. **Physical Form** (To be completed by health care provider.)
6. **Dental Form** (To be completed by dental care provider.)

The Kiowa Tribe Head Start Program will need to verify the **Family's Residential Address** to ensure all mailed correspondence will be received. We must be able to reach you in order to enroll your child. Verification of residential address may include copies of any two of the following: Utility Bill with address on it, Driver's License, and Postmarked Mail.

**If you need assistance in completing the application or have any questions, please contact us at 580-654-2544, toll free at 1-855-711-4010 or feel free to contact your local Kiowa Head Start Center.**

#### REQUIRED DOCUMENTS

The Kiowa Tribe Head Start Program **requires** a copy of the **Eligibility Documents** below before your child can be considered for enrollment. Please include all Eligibility Documents with the **multi-page enrollment application**, originals will be returned.

- Child's Birth Certificate**
- Child's Social Security Card**
- Child's Medicaid Card** (if enrolled in the DHS Program)
- Child's Certificate of Degree of Indian Blood (CDIB)** (if applicable)
- Child's Updated Immunization Record**
- Income Verification** (Verification must include examination of any of the following: Individual Income Tax Form 1040, 1040EZ, W-2 Forms, Pay Stubs, Written Statements from Employers, or Documentation showing current status as recipients of public assistance\*\*).

Please complete and return this Multi-Page Enrollment Application as soon as possible. When we receive your application, we will review it and inform you whether or not your family qualifies for Head Start, or if we need more information.

\* See Policy On Confidentiality on attached page.

\*\* If your family is a current recipient of TANF benefits from DHS, are receiving Supplemental Security Income (SSI), or are providing foster care for the child you are applying for, you automatically qualify for Head Start. You do not need to provide proof of income, but you must provide documentation that your family is currently receiving TANF, SSI, or providing care for a foster child.



## CONFIDENTIALITY POLICY

**OBJECTIVE:** To protect the children, families, and staff's records which are required by the Head Start Performance Standards.

**PROCEDURE:** The following procedures will be used to ensure confidentiality on each child, family, and staff.

1. The parent/guardian must complete the Authorization to Release Information as part of the application process.
2. All records of children, families, and staff must be kept in a locked file cabinet.
3. Access to records will be confined to Head Start Management Team, Lead Teachers, Teacher Aides, Parents, Health, and other professionals.
4. Everyone reviewing the child/family's records must sign the Personnel Access checklist form provided at the front of each file; recording the date, name, and reason for accessing the file.
5. Head Start staff's review of records is limited to information which must be obtained for the purpose of providing services to children and families.
6. Parents/guardians must be informed of what information will be kept confidential and with whom the information will be shared in order to provide assistance.
7. No information about a child or family will be released to an agency or person without a signed *Authorization to Release Information* form.
8. Head Start staff shall not discuss any issues concerning the children or their families with anyone, unless the parent/guardian has signed an *Authorization to Release Information* form.
9. When custody has been awarded to only one parent, access to records shall be limited to the custodial parent only.
10. Staff health records are confidential and maintained by the Head Start Director. Permission from the staff member for review or release of staff health information must be obtained prior to forwarding information to other service providers using the *Authorization for Release of Information* form, unless release of the information to authorized health agencies is required by State, Tribal, or Federal laws. The Head Start Director will consult with the Head Start Advisory Board and decide who among the staff needs access to confidential health information on other staff members before a request for disclosure of such information is made.

# Kiowa Tribe Head Start

Applicant								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID
Race			Hispanic	English Proficiency	Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient				
Primary Health Coverage		Other Coverage	Insurance #	Medicaid Eligibility		Medicaid #	Doctor/Medical Home	
				<input type="checkbox"/> Not Eligible				
				<input type="checkbox"/> On Medicaid				
				<input type="checkbox"/> Potentially				
Dental Coverage		Dental Coverage #				Dentist/Dental Home		

Primary Adult								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID
Race			Hispanic	English Proficiency	Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient				
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:		
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family		
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support		
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew	<input type="checkbox"/> Teen Parent			
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster				
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other				
		<input type="checkbox"/> Master's			If teen parent, subsidized?			
					<input type="checkbox"/> Yes <input type="checkbox"/> No			

Email Address: \_\_\_\_\_

Secondary or Other Adult								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID
Race			Hispanic	English Proficiency	Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient				
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:		
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family		
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support		
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew	<input type="checkbox"/> Teen Parent			
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster				
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other				
		<input type="checkbox"/> Master's			If teen parent, subsidized?			
					<input type="checkbox"/> Yes <input type="checkbox"/> No			

Email Address: \_\_\_\_\_

Additional Child (Non-Applicant) *								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID
Race			Hispanic	English Proficiency	Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient				

Additional Child (Non-Applicant) *								
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID
Race			Hispanic	English Proficiency	Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes	<input type="checkbox"/> None			<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial			<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient				

\* If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.

Applicant Name: \_\_\_\_\_ Birthday \_\_\_\_\_

## Family Information, Income & Contacts

Family Information							
<b>Family Living Address</b>							
Started Living At Date	Living Address	Address Line 2	ZIP	City	State	County	
<b>Family Mailing Address</b>							
Same as living?	Started Using Date	Mailing Address	Address Line 2	ZIP	City	State	
<input type="checkbox"/> Yes <input type="checkbox"/> No							
Phone Number(s)	Type (check one)		Note (for example, an extension or best time to call)				
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other						
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other						
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other						
Parental Status (check one)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (if applicable)
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Income						
Income Verified by		Verification Date		TANF Status		SSI
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly on TANF/Not now		<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Member	Amount	Per (for example: week, month, year)	Annual Amount	Description (for example: SSI, Job, Child Support)	Verification (for example: W2, check stub)	Note
	\$		\$			
	\$		\$			
	\$		\$			
Income Notes						

Emergency Contacts						
Contact 1	Name	Relationship		Emergency Contact		Release To
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	ZIP		City		State
Contact 2	Phone Number 1	Phone Number 2		Phone Number 3		
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
	Name	Relationship		Emergency Contact		Release To
Contact 3				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	ZIP		City		State
	Phone Number 1	Phone Number 2		Phone Number 3		
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

Certification: I certify that this information is true. If any part is false, my participation in 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 \_\_\_\_\_



# Kiowa Tribe Head Start Program



PO Box 369 Carnegie, OK 73015  
(580)654-2300 ext. 359 Fax (580)654-2544

## PARENT/GUARDIAN PERMISSION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

I, \_\_\_\_\_,  
(Parent/Guardian), give the Kiowa Tribe Head Start Program consent to release or obtain from the following agencies and/or persons pertinent social, medical or other information about \_\_\_\_\_ for whom I am legally responsible.  
(Name and DOB of child)

**This consent is valid for one year after the date signed.**

I, the undersigned, do hereby authorize the \_\_\_\_\_ to release information from the record of my child, \_\_\_\_\_ to the following:

\_\_\_\_\_  
(Name of person or firm authorized to receive information)

\_\_\_\_\_  
(Address)

I release the Kiowa Tribe Head Start Program and its staff from any legal liability for disclosing or acquiring information, which I have permitted by signing this form. I also release the above named person(s) and/or agencies from any legal liability for giving information to the Kiowa Tribe Head Start Program for the period stated above.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

I have explained to \_\_\_\_\_ the purpose of this release and the disclosure, which might reasonable be anticipated.  
Parent/Guardian

\_\_\_\_\_  
Signature of Head Start Staff

\_\_\_\_\_  
Date



# Kiowa Tribe Head Start Program



## PARENTAL CONSENT FORM FOR HEALTH SERVICES

Circle While my child, \_\_\_\_\_  
Yes or No is participating in the Kiowa Tribe Head Start Program, I agree:

Yes No 1. To provide the program with necessary health history, which includes medical, nutrition, immunizations, dental, growth, and developmental.

Yes No 2. To provide the program authorization to request and/or provide information concerning screenings and examinations.

Yes No 3. To accompany my child to the necessary sensory health screenings and laboratory test within 45 days after enrollment, dental and physical within 90 days as required by the program.

Yes No 4. In the event of an emergency, the Kiowa Tribe Head Start Program may provide first aid and/or emergency medical care.

Yes No 5. To allow health records to be forwarded to the public school system upon graduation of the Kiowa Tribe Head Start Program.

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I have read and understand each of the above statements. I agree to abide by the Kiowa Tribe Head Start Program guidelines.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Received by:

\_\_\_\_\_  
Signature of Head Start Staff

\_\_\_\_\_  
Date