



## Application

### Child Information:

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
 Birthday: \_\_\_\_\_ Age: \_\_\_\_\_  
 Nick Name: \_\_\_\_\_ Gender:  Male  Female  
 Primary Language:  English  Yupik  Other \_\_\_\_\_  
 Secondary Language:  English  Yupik  Other: \_\_\_\_\_  
 My child is:  Alaska Native/American Indian  African American  Hispanic (full or with other race)  Caucasian  Asian/Pacific Islander  Other: \_\_\_\_\_

### Family Information:

**Primary Parent** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Birth date \_\_\_\_\_  
 Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: (907) \_\_\_\_\_ Work Phone: (907) \_\_\_\_\_ Cell Phone: (907) \_\_\_\_\_  
 Email: \_\_\_\_\_ Email: \_\_\_\_\_

**Secondary Parent** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Birth date \_\_\_\_\_  
 Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: (907) \_\_\_\_\_ Work Phone: (907) \_\_\_\_\_ Cell Phone: (907) \_\_\_\_\_  
 Email: \_\_\_\_\_ Email: \_\_\_\_\_

### Household Information:

Parental Status:  One Parent  Two Parent  Foster Parent  Other \_\_\_\_\_  
 Number of family members in household supported by the income of the parent(s)/guardian(s) of the child listed on the application: \_\_\_\_\_  
 Number of people living in the home: \_\_\_\_\_  
 Number of Children in household: \_\_\_\_\_  
 Ages: 0-3 \_\_\_\_\_ 4-5 \_\_\_\_\_ 6 and older \_\_\_\_\_

### Income/Insurance Information:

**Total Gross Income** \_\_\_\_\_ (Over-Income families may choose to write over-income)

### **Do you or any household member receive? (Check all that apply)**

TANF (Temporary Assistance to Needy Family)  Child Care Assistance  SSI (Supplemental Social Security)  
 WIC  IHS (Indian Health Services)  Denali Kid Care/Medicaid  Private Health Insurance

### Disability:

**Does your child have a disability, special need or significant health issue?**  Yes  No  Suspected  
 If yes explain details (When diagnosed and who diagnosed it): \_\_\_\_\_

**Applicants that have high risk social needs are given priority for enrollment**

### Special Needs or Concerns:

Multiple families household  Deployed Parent (current or returned)  Domestic Violence  Abuse and Neglect  
 Death or serious illness in immediate family  Alcohol or drug use

### CERTIFICATION:

*I 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.*

*I understand that my child will not be considered for enrollment until income documentation and child immunizations have been received*

*I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action.*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Application Received \_\_\_\_\_ Date Waitlisted \_\_\_\_\_ Site Waitlisted: \_\_\_\_\_

Income Attached  Immunizations Attached

Revised 03/2009

\* BBNA Head Start does not discriminate on the basis of race, sex, age color, ethnic or national origin, cultural affiliation, citizenship, religious belief, disability or political standing.