



PLEASE ATTACH A COPY OF THE FOLLOWING INFORMATION TO BE CONSIDERED FOR SCREENING. APPLICATIONS WILL REMAIN ON FILE FOR ONE (1) YEAR.

1. Income Verification for Family (*Must show the Gross amount - Tax Return, W2, Pay Stub, Employer Statement, TANF or Supplemental Security Income (SSI) Documentation. Check stubs must be dated for month previous of the date of the application*)
2. Child's Birth Record (*Birth Certificate, Birth Card, Letter of Live Birth*)
3. Current Immunization Record
4. Cherokee Nation or Federally Recognized Tribal Citizenship Card for child and/or parent (*If applicable*)

Application Date _____ Public School District in which child resides _____

Child's First Name _____ Middle _____ Last Name _____

Date of Birth _____ Gender Male Female

Ethnicity/Race (*circle one*): American Indian/Alaska Native, Asian, Black or African American, Multi-racial/Biracial, Native Hawaiian/Other Pacific Islander, Hispanic, Other, Unspecified, White

Language (*circle one*): English, Cherokee, Spanish, Asian, Native North American, Caribbean, Indic, Western European, Pacific Island, African Languages, Other

Has your child been diagnosed for special needs services? Yes No *If yes, please provide documentation.*

Has your child received services for special needs? Yes No *If yes, please provide documentation.*

Are there other siblings in the household ages 0-4? Yes No

Are the parents employed by Cherokee Nation? Yes No

FAMILY CONTACT INFORMATION:

Mailing Address _____ City _____ State _____ Zip Code _____

Physical Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Message or Work Phone _____

Email address _____

WHAT PROGRAM/CENTER ARE YOU APPLYING FOR:

Head Start

3 and 4 year old children (3 years old as of Sept. 1st)
 Center Hours: Monday – Friday – 7:30 – 2:30

1st Preference: _____

2nd Preference: _____

Tahlequah Children's Village, Kenwood, Shady Grove,
 Salina Early Learning Academy, TPS Sequoyah 3's

Full Day Hours: TCV, SELA

Early Head Start

Children 6 weeks – 3 years old.
 Center Hours: Monday – Friday – 7:30 – 2:30

1st Preference: _____

2nd Preference: _____

Tahlequah Children's Village, Cherry Tree, Jay, Pryor, Redbird,
 Tahlequah Early Learning Academy, Salina Early Learning
 Academy, Wauhillau (Nowata)

Full Day Hours: TCV, TELA, SELA, PRYOR

FULL DAY AVAILABLE AT: TCV / SELA / TELA / PRYOR Will your family need full day hours? YES or NO

Please note that Full Day (beyond 2:30) hours are only available in limited centers and require you to complete an application **once you are enrolled** in the program. **Acceptance to the program does not guarantee a full day slot.**

(Please initial indicating your understanding) _____

FAMILY INFORMATION:PLEASE LIST ALL HOUSEHOLD MEMBERS INCLUDING THE APPLICANT.

Relationship to Child	First Name	Middle Name	Last Name	Date of Birth	Gender – M/F
Applying Child					

PRIMARY PARENT/GUARDIAN'S INFORMATION:

First Name _____ Middle _____ Last Name _____

Date of Birth _____ Gender ___ Male ___ Female Relationship to Child: _____

Opt in for Text Messages Y / N Cell Number: _____

Ethnicity (circle one): American Indian/Alaska Native, Asian, Black or African American, Multi-racial/Biracial, Native Hawaiian/Other Pacific Islander, Hispanic, Other, Unspecified, WhiteLanguage (circle one): English, Cherokee, Spanish, Asian, Native North American, Caribbean, Indic, Western European, Pacific Island, African Languages, OtherDo any of the following apply (Please circle): Lives with Family / Provides Financial Support / Teen ParentHighest Grade Completed (circle one): Master's, Bachelor's, Associate's, College Degree/Training, Advance Training, Grade 10, Grade 11, Grade 12, < Grade 9, HS Graduate, GED, Currently Enrolled in CollegeEmployment Status (circle one): Full Time, Part Time, Seasonal, Unemployed, Full Time & Training, Part Time & Training, Training or School, Retired or Disabled**SECONDARY PARENT/GUARDIAN'S INFORMATION:**

First Name _____ Middle _____ Last Name _____

Date of Birth _____ Gender ___ Male ___ Female Relationship to Child: _____

Opt in for Text Messages Y / N Cell Number: _____

Ethnicity (circle one): American Indian/Alaska Native, Asian, Black or African American, Multi-racial/Biracial, Native Hawaiian/Other Pacific Islander, Hispanic, Other, Unspecified, WhiteLanguage (circle one): English, Cherokee, Spanish, Asian, Native North American, Caribbean, Indic, Western European, Pacific Island, African Languages, OtherDo any of the following apply (Please circle): Lives with Family / Provides Financial Support / Teen ParentHighest Grade Completed (circle one): Master's, Bachelor's, Associate's, College Degree/Training, Advance Training, Grade 10, Grade 11, Grade 12, < Grade 9, HS Graduate, GED, Currently Enrolled in CollegeEmployment Status (circle one): Full Time, Part Time, Seasonal, Unemployed, Full Time & Training, Part Time & Training, Training or School, Retired or DisabledHow did you hear about our program: Another parent Newspaper Teacher/Staff CN Dept. CNTV CN Community Meeting Community Event Other (please specify): _____

AUTHORIZATIONS:

OSIIS RELEASE - Authorization to Pull Immunization Record

I, _____, hereby authorize the Oklahoma Immunization Service to release my child's Immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS") to the Cherokee Nation Early Childhood Unit for the purpose of completing my child's school records file to ensure that my child meets Oklahoma eligibility requirements for schools/day cares as outlined in Title 70 O.S. § 1210.191 and Oklahoma Administrative Code ("OAC") 310:535-1-2 and OAC 310: 535-1-3. Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon my child dropping or completing the Early Head Start/Head Start program at the Cherokee Nation Early Childhood Unit.

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information and revoke this authorization at any time in writing. If I choose to withdraw my permission, I will be responsible for providing updated Immunization records to my child's classroom for the purpose of completing my child's records.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand I may change this authorization at any time in writing. However, I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations.

Parent/Guardian Signature _____ Date _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOUR FAMILY:

1. Foster Child (*Provide Documentation*)
2. Protective Service Referral (*DHS / ICW*)
3. Single Parent or Single Guardian Household
4. Family Crisis (*Please explain*) _____
5. Homeless (*Complete Homeless Questionnaire*)
6. Siblings Currently Enrolled
7. Receiving Public Assistance TANF or SSI (*Provide Documentation*)
8. Receiving SNAP / WIC. (*please circle which*) WIC ID#: _____
9. Active Military Family
10. Military Veteran Family
11. Child receives services from the following programs (*please circle which*): *Sooner Start, HERO Project, Bair Foundation, CREOKS, Evolve Professional Counseling, Cherokee Parents*
12. Family is acquiring/learning another language in addition to English.

Application Comments: _____

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that providing false documentation may disqualify me from receiving services.

Parent/Guardian Signature: _____ Date _____



FAMILY INTERVIEW - ECU Staff Complete



In-Person Telephone (*Document Reason Why Not In-Person*) _____

Please verify the following with the family:

1. Childs Name _____
2. Parent(s)/Guardian(s) Name _____
3. Age Verification _____ 4. Income Verification _____ 5. Family Size _____
6. Household Members _____
7. Child Information _____
8. Family Strengths _____
9. Does the child receive special services from any program: _____
10. Do any of the following apply?: Homeless, Foster, SSI, TANF

Completing Staff Signature: _____

Date: _____