

OLYMPIC COMMUNITY ACTION PARTNERSHIP – EARLY CHILDHOOD SERVICES

Head Start/Early Head Start Enrollment Application

Child Information

Child's Last Name:	First:	Middle:
Preferred Name:		
Date of Birth or Expected Delivery Date:		Language Translator Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multi-racial <input type="checkbox"/> Other (please describe below) Other Race: _____	Ethnicity: <input type="checkbox"/> Hispanic or Latino Origin <input type="checkbox"/> Non-Hispanic/Non-Latino Origin Sex: M F Health Insurance: <input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military <input type="checkbox"/> Employment Based <input type="checkbox"/> Private <input type="checkbox"/> State If Medicaid, PIC#: _____	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Native Central American, South American, & Mexican Languages <input type="checkbox"/> Caribbean Languages <input type="checkbox"/> Middle Eastern & South Asian Languages <input type="checkbox"/> East Asian Languages <input type="checkbox"/> Native North American/Alaska Native Languages <input type="checkbox"/> Pacific Island Languages <input type="checkbox"/> European & Slavic Languages <input type="checkbox"/> African Languages <input type="checkbox"/> Other (please describe below) Other Language: _____

Family/Household Information

	Primary Caregiver	Secondary Caregiver
Relationship to Child >>	<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Foster <input type="checkbox"/> Other <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian	<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Foster <input type="checkbox"/> Other <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian
Name >>	_____	_____
Date of Birth >>	_____	_____
Hispanic or Latino >>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Race >>	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multi-racial <input type="checkbox"/> Other (please describe below) Other Race: _____	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multi-racial <input type="checkbox"/> Other (please describe below) Other Race: _____
Address >>	_____	_____
Address >>	City: _____ ZIP: _____	City: _____ ZIP: _____
Mailing Address >>	_____	_____
Education Level >>	<input type="checkbox"/> Less than high school <input type="checkbox"/> High school grad/GED <input type="checkbox"/> Some college/vocational school <input type="checkbox"/> AA Degree <input type="checkbox"/> BA or advance degree <input type="checkbox"/> Unknown	<input type="checkbox"/> Less than high school <input type="checkbox"/> High school grad/GED <input type="checkbox"/> Some college/vocational school <input type="checkbox"/> AA Degree <input type="checkbox"/> BA or advance degree <input type="checkbox"/> Unknown
Occupation >>	<input type="checkbox"/> Full Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Part Time <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> Temporary Worker <input type="checkbox"/> In School/Training <input type="checkbox"/> Unpaid Volunteer <input type="checkbox"/> Unemployed	<input type="checkbox"/> Full Time <input type="checkbox"/> Self-employed <input type="checkbox"/> Part Time <input type="checkbox"/> Disabled <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> Temporary Worker <input type="checkbox"/> In School/Training <input type="checkbox"/> Unpaid Volunteer <input type="checkbox"/> Unemployed
Health Insurance >>	<input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military <input type="checkbox"/> Employment Based <input type="checkbox"/> Private <input type="checkbox"/> State	<input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Military <input type="checkbox"/> Employment Based <input type="checkbox"/> Private <input type="checkbox"/> State
Phone >>	Home: _____ Cell: _____	Email: _____
Housing Type >>	<input type="checkbox"/> *Homeless <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Temporary Quarters <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other * Homeless means your family is staying in a car, campground or hotel, emergency shelter or transitional housing, or your family is living with another family	
Please select the following items if they apply to either caregiver listed above:		
<input type="checkbox"/> Teen Parent <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parent Family <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Active Duty Military <input type="checkbox"/> Veteran		

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Additional Children in Home (other than the child listed above)

First and Last Name	Date of Birth	Sex	*Relation to Primary Adult	*Relation to Secondary Adult
		M F		
		M F		
		M F		
		M F		
		M F		

***Relation to Adult:** 1) Natural Child 2) Foster Child 3) Grandchild 4) Stepchild 5) Niece 6) Nephew 7) Other (please specify above)

Eligibility Information

Number in Family: _____	Number of children by age: 0 to 3: _____ 4 to 5: _____ 6 & Older: _____
Family Income: (Gross yearly income from all sources) \$ _____	
<input type="checkbox"/> Employment TANF: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type: <input type="checkbox"/> Cash <input type="checkbox"/> Medical <input type="checkbox"/> Food Stamps <input type="checkbox"/> SSI <input type="checkbox"/> Child Care Assistance	

Special Considerations/Priority for Enrollment

Your application does not guarantee the enrollment of your child. We consider income, children with disabilities, agency referrals and other needs of the family to decide enrollment priorities. Please complete all section below in order to receive top priority points.

Has your child been diagnosed with or is your child suspected of having a disability?
 Yes: What? _____ No concerns

Does your child have a current Individual Education Plan (IEP) or an Individual Family Service Plan (IFSP)? Yes No
 (This is a plan for disability services you made with school or agency staff.) **If yes, please include a copy of the IEP/IFSP with this application.**

Please indicate any concerns you have about your child.
 Speech/Language Impairment Emotional/Behavioral Disorder Physical Impairment
 Vision Impairment/Blindness Developmental Delay
 Health Concerns (specify): _____
 Other Concerns (specify): _____

Please indicate any agencies that have or are currently working with your family: (Check all that apply)
 Public Health Dept. First Step Community Health Dept Receiving Special Health Care Services WIC CPS
 School District Staff Healthy Families Olympic Community Action Other _____

If you have any letters of referral from your doctor, visiting nurse, or counselor who thinks your child should be enrolled, please include copies with this application. Referring Agency: _____ Name _____ Phone # _____

Please list any immediate concerns in your family: Food Substance Abuse Pregnant Medical Insurance for Family
 Housing Domestic Violence Legal Isolated/Lack Support Health Problems Transportation Disabilities
 Abuse/Neglect Mental Health Issues Incarcerated Parent

Has anyone in your family received services from Head Start/ECEAP or Early Head Start in the past?
 Yes (Where?) _____ No

How did you hear about Head Start/ECEAP or Early Head Start?
 Internet Community Event Flyer Head Start/Early Head Start/ECEAP Employee Word of mouth
 Caseworker Media Community Agency – Name of agency: _____
 Other (please describe): _____

I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strictest confidence within the agency.

 Parent/Guardian Signature

 Date



Income documentation and birth verification must be included with application to process



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USDA Nondiscrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter



must be submitted to USDA by:

- 1) **mail:**

Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW

Washington, D.C. 20250-9410; or
- 2) **fax:**
(833) 256-1665 or (202) 690-7442; or
- 3) **email:**
Program.Intake@usda.gov

This institution is an equal opportunity provider.