

Olympic Community Action Partnership

Early Childhood Services

Thank you for your interest in enrolling your child in Head Start/Early Head Start/ECEAP.

In order to process your application, we must have the following:

1. **Proof of income for 12 months.** This can be the first page of your most recent tax return which shows your gross income, W-2, or most recent pay stub with Year-to-Date income, TANF or SSI letter, or letter from employer. If you do not have these, please contact us for more instruction.
2. **Proof of birth.** A state or hospital birth certificate (copy) or another legal document such as a passport. ***If you don't have a copy of the birth certificate, don't worry, we have other ways to verify. Please still submit application and income information. ***

Please be sure to fully complete the **Special Considerations/Priority for Enrollment** section on the last page of the application that apply to your family. The program does not enroll on a first come, first served basis but is required to ensure those children and families with the greatest need get the first opportunity.

The application must have a **signature and date** on the last page.

It is important that we have a reliable way to contact you. Write clearly, include phone numbers and e-mail address. If you can only receive a text message, please let us know.

For families of children with diagnosed special needs, please include a copy of their **Current IEP or IFSP**. This ensures they receive the appropriate placement on our wait lists for service.

Return the completed, signed application to:

Carol Johnson/Family Service Specialist
OlyCAP
228 W 1st Street Suite J
Port Angeles, WA 98362
(360) 302-1237
ecsapps@olycap.org

**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 <div style="background-color: yellow;">If Medicaid, PIC#: _____</div>	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

	<u>Primary Caregiver</u>	<u>Secondary Caregiver</u>
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"/> 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"/> Yes <input type="checkbox"/> No <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: _____
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 or 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 or 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 <div style="background-color: yellow;">* 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</div>	
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



**OLYMPIC COMMUNITY ACTION PARTNERSHIP
EARLY CHILDHOOD SERVICES
HEALTH REQUIREMENTS**

HEAD START/ECEAP PARENTS OR GUARDIANS,

Thank you for considering our program for your child. This letter is to inform you of the health requirements of our program.

We require that all children enrolled in our program:

- Are up-to-date on well-child exams
- Are up-to-date on dental exams
- Are up-to-date on immunizations*
- Have had a lead screening test

The reason our program requires that all enrolled children have an up-to-date health status is our philosophy that health is a vital part of school readiness. It is important that your child is physically healthy to be able to fully participate in the learning experience. Regular health care also helps to prevent illness and offers you a chance to ask any questions you have about the health and well-being of your child.

Your Family Service Worker, Home Visitor, or Teacher will help you determine whether your child is up-to-date on these requirements. If your child is not up-to-date, we will support you in making these arrangements while your child is enrolled in our program. *Note that, per Washington state law, your child must be up-to-date on immunizations before the first day your child attends class.

If you have any questions about our health requirements, you may contact me at 360-452-4726 ext. 6220.

Sincerely,

Health Safety Nutrition Coordinator
Early Childhood Services
360-452-4726 ext. 6220

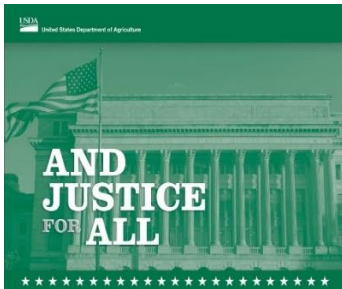


USDA Nondiscrimination Statement:

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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, audiotape, 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.