Olympic Community Action Programs

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 other legal document such as a passport.

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:

Nicholas A Cookro/Family Service Coordinator
OlyCAP
228 W 1st Street Suite J
Port Angeles, WA 98362
(360) 452-4726 Ext. 6223
ncookro@olycap.org

OLYMPIC COMMUNITY ACTION PROGRAMS – 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? ☐ **Yes** ☐ **No**	

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Biracial/Multi-racial
- ☐ Other (please describe below)

Other Race: _____

Ethnicity:
- ☐ Hispanic or Latino Origin
- ☐ Non-Hispanic/ Non-Latino Origin

Sex:
M F

Language:
- ☐ English
- ☐ Spanish
- ☐ Native Central American, South American, and Mexican Languages
- ☐ Caribbean Languages
- ☐ Middle Eastern & South Asian Languages
- ☐ East Asian Languages
- ☐ Native North American/Alaska Native Languages
- ☐ Pacific Island Languages
- ☐ European & Slavic Languages
- ☐ African Languages
- ☐ Other (please describe below)

Other Language: _____

Family/Household Information

	Primary Caregiver	**Secondary Caregiver**
Relationship to Child >>	☐ Mother ☐ Stepmother ☐ Foster ☐ Other ☐ Father ☐ Stepfather ☐ Guardian	☐ Mother ☐ Stepmother ☐ Foster ☐ Other ☐ Father ☐ Stepfather ☐ Guardian
Name >>	_____	_____
Date of Birth >>	_____	_____
Hispanic or Latino >>	☐ Yes ☐ No	☐ Yes ☐ No
Race >>	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Biracial/Multi-racial ☐ Other (please describe below) Other Race: _____	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Biracial/Multi-racial ☐ Other (please describe below) Other Race: _____
Address>>	_____	_____
Address>>	City: _____ ZIP: _____	City: _____ ZIP: _____
Mailing Address >>	_____	_____
Education Level >>	☐ Less than high school ☐ High school grad/GED ☐ Some college/vocational school or AA Degree ☐ BA or advance degree ☐ Unknown	☐ Less than high school ☐ High school grad/GED ☐ Some college/vocational school or AA Degree ☐ BA or advance degree ☐ Unknown
Occupation >>	☐ Full Time ☐ Self-employed ☐ Part Time ☐ Disabled ☐ Migrant Worker ☐ Retired ☐ Seasonal Worker ☐ Temporary Worker ☐ In School/Training ☐ Unpaid Volunteer ☐ Unemployed	☐ Full Time ☐ Self-employed ☐ Part Time ☐ Disabled ☐ Migrant Worker ☐ Retired ☐ Seasonal Worker ☐ Temporary Worker ☐ In School/Training ☐ Unpaid Volunteer ☐ Unemployed
Health Insurance >>	☐ None ☐ Medicaid ☐ Medicare ☐ Military ☐ Employment Based ☐ Private ☐ State If Medicaid, PIC#: _____	☐ None ☐ Medicaid ☐ Medicare ☐ Military ☐ Employment Based ☐ Private ☐ State If Medicaid, PIC#: _____
Phone >>	Home: _____ Cell: _____ Email: _____	
Housing Type >>	☐ *Homeless ☐ Own ☐ Rent ☐ Temporary Quarters ☐ Other Permanent Housing ☐ 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:

☐ Teen Parent ☐ Single Parent ☐ Two Parent Family ☐ Foster Parent ☐ Grandparent ☐ Active Duty Military ☐ 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) $_____	
☐ Employment TANF: ☐ Yes ☐ No	
Type: ☐ Cash ☐ Medical ☐ Food Stamps ☐ SSI ☐ 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**