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:	**Ethnicity:**	**Language:**
☐ 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: _______________	☐ Hispanic or Latino Origin ☐ Non-Hispanic/ Non-Latino Origin **Sex:** M F **Health Insurance:** ☐ None ☐ Medicaid ☐ Medicare ☐ Military ☐ Employment Based ☐ Private ☐ State If Medicaid, PIC#: ___________	☐ English ☐ Spanish ☐ Native Central American, South American, & 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	☐ None ☐ Medicaid ☐ Medicare ☐ Military ☐ Employment Based ☐ Private ☐ State
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**

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