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 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 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

Health Insurance:
☐ None ☐ Medicaid ☐ Medicare
☐ Military ☐ Employment Based
☐ Private ☐ State

If Medicaid, PIC#: _____

Language:
- ☐ 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

OLYMPIC COMMUNITY ACTION PROGRAMS – EARLY CHILDHOOD SERVICES
Head Start/Early Head Start Enrollment Application

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**

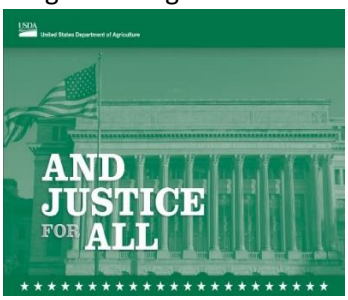
Income documentation and birth verification must be included with application to process

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, 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.