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 ☐ Hispanic or Latino Origin ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Bi-Racial or Multi-Racial ☐ Other (*comments required*) ☐ Unspecified	☐ Hispanic or Latino Origin ☐ Non-Hispanic/ Non-Latino Origin **Sex:** M F	☐ English ☐ Spanish ☐ Native Central American; South American & Mexican Languages ☐ Caribbean Languages ☐ Middle Eastern & South Asian Languages ☐ East Asian Languages ☐ Native North American or Alaska Native Languages ☐ Pacific Island Languages ☐ European & Slavic Languages ☐ African languages ☐ Other (*comments required*)

Family Information

Relationship to Child >>	☐ **Mother**	☐ **Father**	☐ **Guardian** ☐ **Stepmother** ☐ **Stepfather** ☐ **Foster** ☐ **Other**
Name >>	_____	_____	_____
Address >>	_____	_____	_____
Mailing Address >>	_____	_____	_____

Phone: Home _____ Cell _____ Message _____ Email _____

Number in Family: Number of children by age: **0 to 3**: **4 to 5**: **6+ & older**:

Homeless? ☐ Yes ☐ No
(*This means your family is staying in a car, campground or hotel, emergency shelter or transitional housing, or your family is living with another family*.)

Are you a: ☐ Teen Parent? ☐ Single Parent? ☐ Two Parent Family? ☐ Foster Parent? ☐ Grandparent? ☐ US Military Parent? ☐ Other?_____

Medical Insurance & Number: If Medicaid, PIC#:

Eligibility Information

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 sections 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 Mental Health ☐ 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? _____

(*Please continue to back page*)

Adults – Family Member Information

First and Last Name	Date of Birth	Sex	Educational Level	Employed? Yes No	Occupation
Primary Adult		M F			
Secondary Adult		M F			

Education:	Occupation:		Notes: Training Programs, etc.
Less than high school	Full time		______________
High school/GED	Self-employed	Seasonal worker	______________
Some college/vocational school or AA Degree	Part time	Migrant worker	______________
BA or advanced degree	Disabled	School/Training	______________
Unknown	Retired	Unpaid volunteer	
	Temporary worker		

Children in Home (*excluding enrolling child*)

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

Related How?: Natural child, Foster child, Grandchild, Stepchild, Niece, Nephew, Other (*specify*)

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**

TO BE COMPLETED BY AGENCY

Head Start / Early Head Start Only

ELIGIBILITY VERIFICATION

Elig.- Parent Status: Pt.:	**Elig.-Disability: Pt.:**	**Elig.-Income: Pt.:**
Elig. Other: Pt.:	**Elig.-Age: Pt.:**	
TOTAL ELIG.-RATING		
Birth Verified: ☐ Yes ☐ No	**By: ☐ Certified Birth Certificate ☐ Hospital Birth Certificate ☐ Health Dept. ☐ Other**	
Income Verification: ☐ Yes ☐ No	**By: ☐ W-2 ☐ Check Stub ☐ Tax Return ☐ Letter ☐ Other**	
Verifying Staff Member:		**Date:**

RE-VERIFICATION

Elig.- Parent Status: Pt.:	**Elig.-Disability: Pt.:**	**Elig.-Income: Pt.:**
Elig. Other: Pt.:	**Elig.-Age: Pt.:**	**Elig.-College Student/MAV Resident: Pt.:**
TOTAL ELIG.-RATING		
Birth Verified: ☐ Yes ☐ No	**By: ☐ Certified Birth Certificate ☐ Hospital Birth Certificate ☐ Health Dept. ☐ Other**	
Income Verification: ☐ Yes ☐ No	**By: ☐ W-2 ☐ Check Stub ☐ Tax Return ☐ Letter ☐ Other**	
Verifying Staff Member:		**Date:**

RE-VERIFICATION

Elig.- Parent Status: Pt.:	**Elig.-Disability: Pt.:**	**Elig.-Income: Pt.:**
Elig. Other: Pt.:	**Elig.-Age: Pt.:**	**Elig.-College Student/MAV Resident: Pt.:**
TOTAL ELIG.-RATING		
Birth Verified: ☐ Yes ☐ No	**By: ☐ Certified Birth Certificate ☐ Hospital Birth Certificate ☐ Health Dept. ☐ Other**	
Income Verification: ☐ Yes ☐ No	**By: ☐ W-2 ☐ Check Stub ☐ Tax Return ☐ Letter ☐ Other**	
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