



**DEPARTMENT OF
CHILDREN AND FAMILIES**

**COUNTY COUNCILS FOR YOUNG CHILDREN
COMMUNITY ORGANIZATION ENROLLMENT FORM**

Name of Agency: _____ **Date:** _____

Agency Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Please indicate agency type, select all that apply:

<input type="checkbox"/>	EB Home Visiting	<input type="checkbox"/>	CCR&Rs	<input type="checkbox"/>	Government
<input type="checkbox"/>	EHS/HS	<input type="checkbox"/>	DFD	<input type="checkbox"/>	Early Intervention
<input type="checkbox"/>	School-Based / Teens	<input type="checkbox"/>	Early Care & Education	<input type="checkbox"/>	Special Child Health Services
<input type="checkbox"/>	Family Success Centers	<input type="checkbox"/>	Child Welfare DCP&P	<input type="checkbox"/>	School District
<input type="checkbox"/>	Board of Social Services	<input type="checkbox"/>	Parent Advocacy	<input type="checkbox"/>	Before & After School Programs
<input type="checkbox"/>	Business	<input type="checkbox"/>	Faith-Based	<input type="checkbox"/>	Other, specify:

Please indicate the services and resources your agency provides, select all that apply:

<input type="checkbox"/>	Translation	<input type="checkbox"/>	Emergency Housing/Food	<input type="checkbox"/>	Medical Home/Primary Care
<input type="checkbox"/>	Counseling	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	Fatherhood Support
<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Library	<input type="checkbox"/>	Case Management
<input type="checkbox"/>	Substance Use	<input type="checkbox"/>	Arts & Recreation	<input type="checkbox"/>	Food/SNAP
<input type="checkbox"/>	Domestic Violence	<input type="checkbox"/>	Child Care	<input type="checkbox"/>	Immigration
<input type="checkbox"/>	Life Skills	<input type="checkbox"/>	Literacy	<input type="checkbox"/>	Faith/Spirituality
<input type="checkbox"/>	Education	<input type="checkbox"/>	Job Training	<input type="checkbox"/>	Employment
<input type="checkbox"/>	Philanthropy	<input type="checkbox"/>	Advocacy	<input type="checkbox"/>	Other, specify:

Please indicate the consumers (target population) of your services, select all that apply:

<input type="checkbox"/>	Infants	<input type="checkbox"/>	Mothers	<input type="checkbox"/>	Grandparents/Relative Caregivers
<input type="checkbox"/>	Toddlers	<input type="checkbox"/>	Fathers	<input type="checkbox"/>	LGBTQI
<input type="checkbox"/>	Young Children	<input type="checkbox"/>	Adoptive Parents	<input type="checkbox"/>	Children w/ Disabilities
<input type="checkbox"/>	Teens	<input type="checkbox"/>	Foster/Resource Parents	<input type="checkbox"/>	Adults w/ Disabilities
<input type="checkbox"/>	Parenting Teens	<input type="checkbox"/>	Elderly	<input type="checkbox"/>	Professionals
<input type="checkbox"/>	Veterans	<input type="checkbox"/>	Military Families	<input type="checkbox"/>	Other, specify:

Please indicate the age ranges for children for which you provide services, select all that apply:

<input type="checkbox"/>	Prenatal	<input type="checkbox"/>	Age: 3 yrs. to 4 yrs.	<input type="checkbox"/>	Age: Over 8 yrs.
<input type="checkbox"/>	Age: Under 3 yrs.	<input type="checkbox"/>	Age: 5 yrs. To 8 yrs.	<input type="checkbox"/>	None, we do not provide services to children

Agency Representative Name: _____ **Title:** _____

Telephone: _____ Work Cell **Email:** _____

Name of your Program Supervisor/Manager: _____

Telephone: _____ Work Cell **Email:** _____

Name of your Agency's Executive Director: _____

Telephone: _____ Work Cell **Email:** _____



COUNTY COUNCILS FOR YOUNG CHILDREN

COMMUNITY ORGANIZATION ENROLLMENT FORM

Please provide the following demographic information.

Gender:

- Male
- Female
- Not Reported

Primary Language:

- English
- Spanish
- Arabic
- Caribbean (French-Creole/Haitian)
- European or Slavic
- Pacific Island
- Eastern Asian (Japanese, Vietnamese)
- Native North American or Alaska Native
- African
- Other (specify): _____

Ethnicity:

- Hispanic origin
- Not of Hispanic origin

Race, select all that apply:

- Black
- White
- Asian or Pacific Islander
- American Indian or Alaskan Native
- Multiracial
- Other (specify) _____

Highest Education Level:

- Less than High School
- High School or GED
- Some college, less than 2 yrs.
- Associate's Degree
- Bachelor's Degree
- Master's Degree or higher

Country of origin: _____

Please indicate any special accommodations needed to support your participation in the Council, select all that apply:

- translation services hearing impaired visually impaired physical challenges: please specify,

How did you hear about the County Council for Young Children (CCYC)? _____

What skills or expertise would you bring to the Council? _____

Will you, the agency representative, commit to bringing at least one parent/caregiver to the CCYC? Yes No

When would be the best time to schedule Council meetings? Morning Afternoon Evening Weekend



COUNTY COUNCILS FOR YOUNG CHILDREN

COMMUNITY ORGANIZATION ENROLLMENT FORM

Help us to understand more about your interest in the County Council for Young Children. Below is a preliminary list and description of Council activities and workgroup opportunities. Let us know if you are interested in helping to address any of the following priorities (select all that apply):

- At this time, I am only interested in attending the General Council Meetings**
- Steering Committee:** This group meets regularly in between general meetings to decide on the priorities of the organization and manages the general course of its operations.
- Education:** This group discusses issues and concerns regarding:
- Quality early care and education programs which may include—Child Care Centers, Family Child Care, Early Head Start/Head Start, Preschool, and Elementary School
 - Transitions for children and their families within early care and education settings—for example, from child care to preschool or from Early Head Start/Head Start/Preschool to Kindergarten.
 - Children with special educational needs
 - Educational needs of parents and caregivers, for example GED programs, vocational training, English as a Second Language (ESL) classes, Community College or other education opportunities
- Health:** This group provides input on health related issues and services in the community that impact:
- Healthy pregnancy / birth; infant/child health and development, including dental care
 - Children with special health care needs
 - Parent/caregiver health – access to health insurance, routine medical care, dental care. And access to related health services when needed—such as, smoking cessation, mental health, substance abuse treatment, and more.
- Art and Recreation:** This group examines opportunities in the community for children and families to have access to art, dance, music and sport activities that are affordable.
- Community Resources:** This group helps to identify available resources and services in the community to identify locations, access, and gaps in services; and helps to recommend improvement, as needed.
- Gaps might include transportation, language and cultural barriers, etc.
- Other - please identify other interests:** _____

Would you be interested in having a coach or mentor to support your participation on the CCYC? Yes No

Would you be interested in hosting a Café meeting in your location? Yes No
If yes, please specify the best time: Morning Afternoon Evening

Are you willing to provide free training for parents and staff? Yes No
If yes, please specify the best time: Morning Afternoon Evening

Topics: _____

*Thank you for completing the County Council enrollment form.
The information that you provide will help us to create an environment that promotes the active involvement of all participants; and ensures that your concerns are heard, supported and acted upon.*