AMERICAN CIVIL LIBERTIES UNION FOUNDATION

August 13, 2025

VIA ELECTRONIC SUBMISSION

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Re: Notice: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit", Docket No. AHRQ-2025-0002

Dear Secretary Kennedy,

The American Civil Liberties Union ("ACLU") submits these comments in opposition to the Department of Health and Human Services' ("HHS") unlawful, harmful, and sweeping immigrant exclusion directive (hereinafter "Directive") upending HHS' longstanding and reasoned interpretation of what constitutes a "federal public benefit" under the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA").[1]

For more than 100 years, the ACLU has been our nation's guardian of liberty, working in courts, legislatures, and communities to defend and preserve the individual rights and liberties that the Constitution and laws of the United States guarantee to everyone in this country. With more than six million members, activists, and supporters, the ACLU is a nationwide non-partisan public-interest organization that fights tirelessly in all 50 states, Puerto Rico, and Washington, D.C. to advance the principle that every individual's rights must be protected equally under the law, regardless of race, religion, gender, sexual orientation, gender identity or expression, disability, national origin, citizenship status, or record of arrest or conviction.

By declaring that thirteen critical programs shall no longer be open to all in need and shall instead be newly subject to immigration status restrictions, HHS' sweeping July 2025 Directive repudiated a settled viewpoint that the agency — and the stakeholders that receive and provide these vital services — have relied upon for nearly three decades. The Directive has triggered chaos and uncertainty both for administering agencies and the individuals, families, and communities who rely on the services at stake. The resulting disenrollment from these programs, including of eligible children and families, will significantly harm the educational and health outcomes of the communities that the ACLU serves. It will

[1] This comment focuses exclusively on the HHS Directive, one of the most consequential of several recently issued directives reinterpreting which federally funded programs carry immigration restrictions as federal public benefits. The ACLU also opposes related notices issued by the Departments of Justice, Agriculture, Education, and Labor in July, which suffer from similar deficiencies as the HHS Directive.

deprive children of access to crucial early educational programming and undermine access to essential and life-saving health care for children and their families. It will also disproportionately burden mixed-status families, people with disabilities, and survivors of gender-based violence.

Indeed, because of the immediate harms to Head Start participants on July 21, 2025, the ACLU filed a motion for a temporary restraining order in its ongoing lawsuit on behalf of Head Start parents and providers to halt the Directive from taking continual effect. *See* Plaintiffs' Motion for Temporary Restraining Order, *Wash. State Ass'n of Head Start & Early Childhood Assistance & Educ. Program et al. v. Robert F. Kennedy, Jr. et al.*, No. 2:25-cv-00781-RSM (W.D. Wash. 2025), attached in entirety as Exhibit 1 to this comment.[2] Nineteen states and the District of Columbia have also filed a lawsuit seeking preliminary relief based on the imminent financial burden of implementing and administering costly verification systems and the harms to programs' integrity by undermining community programs that states have designed to be broadly accessible to all in need. *See* Plaintiff States' Motion for a Preliminary Injunction and Request for Emergency Relief, *New York v. U.S. Dep't of Justice*, No. 1:25-cv-00345-MSM-PAS (D.R.I. July 21, 2025).

For the reasons raised in these lawsuits and discussed below, the ACLU urges HHS to withdraw the Directive in its entirety.

A. Statutory and Regulatory Background

PRWORA, enacted in 1996, imposed immigrant status eligibility requirements on a specific range of programs determined to be a "federal public benefit," a term defined to include enumerated benefits and those "similar" to them, a definition that excludes many forms of payment and assistance from the Federal government. 8 U.S.C. § 1611(c)(1)(B). PRWORA also enumerates certain categories of non-citizens as "qualified" immigrants and others as not "qualified" immigrants for purposes of assessing federal public benefits eligibility, subject to certain exceptions. "Qualified" immigrants are defined as Lawful Permanent Residents, refugees, persons granted asylum, and five other, less common, categories of immigrants. All other immigrants are not "qualified." Excluded immigrants include undocumented immigrants as well as millions of people who are lawfully present in the United States, including individuals with Temporary Protected Status, non-immigrant visa holders (such as people with a student or work visa, or survivors of serious crimes granted U visas), and individuals granted deferred action, including Deferred Action for Childhood Arrivals. Because the list of qualified immigrants is so restrictive, any new designation of a specific program as a "federal public benefit" carries severe consequences not only for immigrants but for the communities in which they reside and for the organizations and agencies who administer the services.

In 1998, following PRWORA's enactment, HHS issued a Notice interpreting the term "federal public benefit" and designating which Department programs met the statutory definition ("1998 Notice"). This notice identified 31 programs, including Medicare, Medicaid, Temporary Assistance for Needy

[2] On August 8, 2025, the Court converted the motion into a motion for preliminary injunction set to be heard on September 9, 2025.

Families, and a range of cash-assistance programs. However, HHS determined that many other programs did not fall under PRWORA's definition and therefore should remain open to all in need, without immigration restrictions. The 1998 notice provided a reasoned interpretation of the statutory definition to explain which programs fell under and outside of the statutory definition. Despite ample opportunities nearly three decades, neither Congress nor any subsequent administration, has sought to alter this interpretation until the present moment.

On July 14, 2025, the Department disavowed the 1998 Notice interpretation and identified 13 additional programs as restricted federal public benefits, including early education programs like Head Start and numerous critical community health and mental health programs. The restricted programs are critical to our nation's wellbeing. For instance, community health centers help keep everyone healthy,[3] avoiding costly chronic and contagious illnesses. Mental health and substance use treatment programs help fill critical gaps in services to people with disabilities and reduce the number of unhoused people.[4] Head Start ensures that children are prepared for K–12 education, guaranteeing that school resources are used efficiently.[5] The preexisting interpretation of PRWORA's scope was well-considered and longstanding. Reversing it will not only harm people and their communities, but also will impose burdensome new requirements on state and local governments and will reduce their capacity to serve everyone.
The new interpretation was effective immediately upon its publication, though HHS subsequently agreed to refrain from implementing the directive until September 10, 2025, in response to litigation challenging it. The abrupt change in policy and lack of time to consider significant individual, public health, and economic implications demonstrates the administration's unnecessary and arbitrary haste and tunnel vision to prioritize its anti-immigrant crusade no matter the harms and cost.

B. HHS' Unprecedented Directive Is Unlawful

The Directive is unlawful because it is contrary to law, arbitrary and capricious, and fails to observe procedure required by law, and therefore violates the Administrative Procedure Act ("APA"). *See* 5 U.S.C. § 706(2).

The Directive Is Contrary to Law. HHS' new designations unlawfully conflict with the plain language of PRWORA, the authorizing statutes that articulate more inclusive eligibility criteria for the specific programs at issue, or both. In the case of Head Start, for example, the HHS directive is unlawful for both reasons. PRWORA defines "federal public benefit" to include "postsecondary education." 8 U.S.C. § 1611(c)(B). Head Start is plainly not postsecondary education, as HHS noted in its original

[3] *Impact of the Health Center Program*, Bureau of Primary Health Care, Health Res. & Servs. Admin., Dep't of Health & Hum. Servs. (Aug. 2025), https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program.
[4] Stacy Mosel, *Substance Abuse and Homelessness: Statistics and Rehab Treatment*, American Addiction Centers (Apr. 1, 2025), https://americanaddictioncenters.org/rehab-guide/addiction-statistics-demographics/homeless.
[5] Nat'l Head Start Ass'n, *Facts and Impacts*, https://nhsa.org/resource/facts-and-impacts/ (last visited Aug. 12, 2025).

interpretation, and as HHS admits (as it must).[6] HHS' argument that Head Start is nevertheless a benefit that is "similar" to "welfare" is strained and unconvincing. Head Start is fundamentally an education program limited to early childhood education and therefore falls outside PRWORA's "post-secondary" specification. That some Head Start programs may incorporate nutritional and other services (as do many K–12 educational programs) does not convert the program into, or make it "similar to," welfare. In addition, the Head Start Act itself establishes "criteria for eligibility," specifying groups of children who "shall" be eligible or deemed eligible, with no indication of any immigration status restrictions. 42 U.S.C. § 9840(a)(1)(B).[7]

The Directive Is Arbitrary and Capricious. Furthermore, Defendants' sudden sweeping reinterpretation of PRWORA is arbitrary, and willfully disregards the enormous, short- and long-term harms for individuals and families who will lose access to newly designated programs.

Such systematic indifference to the consequences for immigrant children, families, and communities — as well as for vulnerable citizens who may lack readily available verification of their citizenship status — is not only cruel, but illegal. Notably, as discussed below, HHS deprived the public of the right to comment on the impact of upending its longstanding interpretation before allowing the Directive to take effect.

First, HHS' Directive abandons decades of existing policy without meaningfully considering "important aspects of the problem," including the significant reliance interests of affected individuals, children and families, and organizations and agencies who serve them. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43 (1983). HHS has for decades made clear that various newly designated programs are not a "federal public benefit" under PRWORA. As a result, organizations administering these programs have never screened participants based on immigration status, allowing staff to build the community trust necessary for program recruitment and retention. Similarly, families have relied on the longstanding interpretation when enrolling their children in programs without fear of increased scrutiny of their immigration status or other negative repercussions. The HHS Directive now forces administering organizations to abruptly change course in program implementation while disrupting access to critical services. Such disruptions have severe and lasting harms, especially for people with disabilities or who are otherwise historically marginalized and/or vulnerable. Because HHS failed to

[6] "Although the litany of categories in 401(c)(1)(B) is broad, it is not comprehensive and clearly excludes certain categories from the definition. For example, by explicitly identifying 'postsecondary education' the statute excludes non postsecondary education programs, such as Head Start and elementary and secondary education." Dep't of Health & Hum. Servs., Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA): Interpretation of "Federal Public Benefit," 63 Fed. Reg. 41658 (Aug. 4, 1998).

[7] For additional arguments regarding the unlawfulness of HHS' unexpected designation of Head Start as a "federal public benefit," see Plaintiffs' Motion for Temporary Restraining Order/To Postpone Effective Date of Agency Action, *Wash. State Ass'n of Head Start & Early Childhood Assistance & Educ. Program v. Robert F. Kennedy, Jr.*, Case No. 2:25-cv-00781-RSM (W.D. Wash. July 21, 2025).

weigh any of these significant reliance interests against competing policy concerns, the directive is arbitrary and capricious.[8]

Moreover, despite acknowledging that the Directive will have a significant economic impact, 90 Fed. Reg. at 31238, HHS has not meaningfully considered the significant costs and burdens that the Directive imposes on agencies and organizations that operate newly designated programs, and failed entirely to quantify or even acknowledge the economic, social, and health costs for impacted individuals, children, families, businesses, educational institutions, state and local governments, and communities at large.[9]

Additionally, because the Directive imposes restrictions on participation in newly designated programs without providing any guidance on how to comply with the requirements, it leaves agencies without standards for determining whether they comply.[10] The lack of clear guidance, coupled with the Directive's threat to "pay heed to the clear expressions of policy," leave affected individuals and families, as well as the agencies implementing these programs, at the "unfettered discretion" of HHS, with "no method by which the [programs] can gauge their performance" or compliance. *Ariz. Cattle Growers' Ass'n v. U.S. Fish & Wildlife*, 273 F.3d 1229, 1250 (9th Cir. 2001).

The Directive Fails to Observe Required Procedure. HHS's issuance of the Directive, which took immediate effect and provides only 30 days for comment, violates the notice and comment requirements of the APA. Under the APA, agencies must publish proposed rules and allow the public an opportunity to comment. 5 U.S.C. § 553(c). "The greater the public interest in a rule, the greater reason to allow the public to participate in its formation."[11] For a Directive upending decades of precedent, and impacting tens of billions of dollars in federal funding profoundly impacting the lives and well-being of a vast

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[8] *Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 591 U.S. 1, 33 (2020); *see also Immigrant Defs. Law Ctr. v. Noem*, No. 25-2581, 2025 WL 2017247, at *11 (9th Cir. July 18, 2025) ("Merely saying something was considered is not enough to show reasoned analysis." (internal citation and quotation marks omitted)).

[9] *See City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.*, 408 F. Supp. 3d 1057, 1106 (N.D. Cal. 2019), *aff'd*, 981 F.3d 742 (9th Cir. 2020) (failure to consider costs of disenrollment from benefits programs of Public Charge Rule was likely unlawful under APA); *see also Ctr. for Biological Diversity v. Bernhardt*, 982 F.3d 723, 750 (9th Cir. 2020) (finding agency action was arbitrary).

[10] *See Ariz. Cattle Growers' Ass'n v. U.S. Fish & Wildlife*, 273 F.3d 1229, 1233 (9th Cir. 2001) (holding agency action was arbitrary and capricious because it "issue[d] terms and conditions so vague as to preclude compliance therewith").

[11] *E. Bay Sanctuary Covenant v. Barr*, 385 F. Supp. 3d 922, 947–48 (N.D. Cal. 2019) (quoting *Hoctor v. U.S. Dep't of Agric.*, 82 F.3d 165, 171 (7th Cir. 1996) (Posner, J.)). Because the Directive creates new "rights [and] duties" for Head Start participants by imposing a categorical bar to eligibility for any "unqualified" immigrant it is "properly considered to be a legislative rule" subject to the APA's notice and comment requirement. *Gen. Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984); *see also Elec. Privacy Info. Ctr. v. U.S. Dep't of Homeland Sec.*, 653 F.3d 1, 6–7 (D.C. Cir. 2011) (a legislative rule "effects 'a substantive regulatory change' to the statutory or regulatory regime" (quoting *U.S. Telecom Ass'n v. F.C.C.*, 400 F.3d 29, 34–40 (D.C. Cir. 2005)).

number of agencies, individuals, families, and communities, this lack of time for public input is deeply inadequate.

HHS effectively concedes that the Directive requires notice and comment but argues that the Directive must take effect before the 30-day comment period concludes because "any delay would be contrary to the public interest," and therefore good cause exists for the rule to take immediate effect. 90 Fed. Reg. at 31238. But HHS does not meet the standard for invoking the "good cause" exception.[12] The exception is an "emergency procedure" that must be "narrowly construed and only reluctantly countenanced."[13] HHS does not meet this narrow standard. The Directive states that "additional delay to correct the deficiencies of the 1998 Notice would fail to remove incentives to illegal immigration that are exacerbating the invasion at the Southern Border," and references one "report" that addresses immigration trends generally from 2020 to 2024. 90 Fed. Reg. at 31238. But HHS cites no evidence linking participation in early education programs like Head Start to increased immigration of any form, lawful or unlawful. Its claim that these programs are an incentive for immigration and that a 30-day delay in the effective date will "exacerbate the invasion" are far too "speculative" to support a finding of good cause.[14]

Please see Exhibit 1, Plaintiffs' Motion for Temporary Restraining Order/To Postpone Effective Date of Agency Action, for a more complete set arguments regarding the unlawfulness of HHS' Directive.

C. The Directive Harms Communities

1. **HHS' restrictions would cause severe harm to families whose children are enrolled in Head Start**

HHS's own analysis estimates that the Directive will have the effect of excluding hundreds of thousands of children from Head Start,[15] a number that does not account for the predictable and intended broader chilling effect on "qualified" immigrant families.[16] A child's loss of access to Head Start means sudden

[12] *U.S. v. Valverde*, 628 F.3d 1159, 1164 (9th Cir. 2010) (an agency "must overcome a high bar if it seeks to invoke the good cause exception to bypass the notice and comment requirement").
[13] *E. Bay Sanctuary Covenant v. Trump*, 909 F.3d 1219, 1253 (9th Cir. 2018) (E. Bay II) (internal quotation marks and citation omitted). The Ninth Circuit has recognized that good cause exists only "where [an] agency cannot 'both follow [notice and comment requirements] and execute its statutory duties'" or where "'delay would do real harm' to life, property, or public safety.'" *California v. Azar*, 911 F.3d 558, 576 (9th Cir. 2018) (internal citations omitted).
[14] *E. Bay II*, 909 F.3d at 1253 (government failed to establish good cause where there was no evidence that delay in effective date would "would give aliens a reason n to 'surge' across the southern border in numbers greater than is currently the case").
[15] *See* Exec. Secretariat, Immediate Off. of the Sec'y, Dep't of Health & Hum. Servs., Final Regulatory Impact Analysis, Docket No. AHRQ-2025-0002 (2025) (hereinafter "RIA") at 7–8.
[16] Defendants' public statements about the Directive misleadingly signal that no immigrants are permitted in Head Start programs. *See* U.S. Dep't of Health & Hum. Servs., *HHS Bans Illegal Aliens from Accessing its Taxpayer-Funded Programs* (July 10, 2025), https://www.hhs.gov/press-

and major disruptions to early childhood education, including critical dual language instruction, disability-related supports, and a safe and stable learning environment.[17] Such disruptions at a young age will have severe immediate and long-term harms to children's development, physical and mental health, self-esteem, sense of stability, and overall well-being, particularly for children with disabilities or developmental delays.[18]

Without access to Head Start's early education and care, parents face much greater risk of missing work, losing their jobs, and/or dropping out of school and training programs, which in turn jeopardizes their ability to pay rent and utilities, buy groceries, cover medical costs, and otherwise support their families.[19] The sudden disruption of these programs may even lead to housing insecurity and homelessness for some families.[20] These harms also will extend beyond impacted children and families, with collateral economic, social, and public health costs for employers, educational and vocational programs, and communities. [21]

Head Start providers are already facing harm and uncertainty as a result of HHS' Directive. Many Head Start agencies have devoted decades-long outreach and recruitment efforts towards building community trust in Head Start as a safe and inclusive learning environment for all children.[22] Head Start Associations challenging the action believe that the Directive will result in drops in enrollment as high as 30 percent.[23] Because funding is based on enrollment, thousands of Head Start teachers and staff are at risk of losing their jobs.[24] Indeed, even an enrollment decrease of just a few children could result in the loss of a Head Start teacher.[25] And some Head Start providers could be forced to close altogether.[26]

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room/prwora-hhs-bans-illegal-aliens-accessing-taxpayer-funded-programs.html ("Head Start is among the programs included in the updated and expanded list of classified 'Federal public benefits' under PRWORA to ensure enrollment in *Head Start is reserved for American citizens from now on*." (emphasis added)).

[17] *See Doe v. Noem*, No. 2:25-cv-00633-DGE, 2025 WL 1141279, at *8 (W.D. Wash. Apr. 17, 2025) (disruption of educational programs or progress constitutes irreparable harm); *see also Tully v. Orr*, 608 F. Supp. 1222, 1225–26 (E.D.N.Y. 1985) (same); Unless otherwise indicated, citations to Plaintiffs' declarations refer to declarations in support of Plaintiffs' Motion for a Temporary Restraining Order, Doc. 79 (Exhibit 1). Doutherd ¶29; Maunnamalai ¶¶38–40; McFalls ¶¶26–29; Morrison-Frichtl ¶¶13, 33; Ryan ¶¶54–56; Williams ¶37.

[18] Doutherd ¶¶29–30; Maunnamalai ¶¶38–40; McFalls ¶¶26–29; Morrison-Frichtl ¶¶32–34; Ryan ¶¶54–56; Williams ¶¶37–38.

[19] *Id*.

[20] Doutherd ¶30; Williams ¶38.

[21] Zaslow Decl. ISO Pls. Mot. Preliminary Injunction, Doc. 51 ¶¶59–61; see also McFalls ¶29.

[22] Maunnamalai ¶¶17, 21, 31, 33–35, 37, 44; McFalls ¶¶6, 35; Morrison-Frichtl ¶¶13–14, 24–25, 31–36; Ryan ¶¶29–30.

[23] Maunnamalai ¶¶31; McFalls ¶51; Ryan ¶¶35–36; Morrison-Frichtl ¶27.

[24] Maunnamalai ¶¶36, 44; Ryan ¶¶42, 58.

[25] Maunnamalai ¶36.

[26] Maunnamalai ¶43.

Even those who are able to successfully navigate the risks face harm to their mission of supporting low-income children and families in their communities.[27]

2. HHS' restrictions on care through Title X and the Health Center Program would severely undermine access to essential health care, including primary care, family planning, and life-saving preventive and public health services

By sweeping the Title X Family Planning Program and the Health Center Program under PRWORA's prohibition, the Directive would strip away essential health services for millions of people, with profound consequences for those individuals, their communities, and the public at large.

The Title X Family Planning Program is the only dedicated source of federal funding for family planning services in the United States. The program provides high-quality family planning and sexual health care to all, with priority given to the low-income patients the program was established to serve. Title X provides access to effective contraceptive methods, cancer screenings, testing and treatment for STIs (including HIV), other preventive services, and, fundamentally, the education and clinical care needed to either achieve or prevent pregnancy — decisions made by patients according to their needs and values. For over half a century, Title X funding has built and sustained a national network of family planning health centers that deliver these critical preventive health services. Title X patients are disproportionately low-income, with the majority having incomes at or below the federal poverty level[28] — $15,650 per year for a single-person household in 2025.[29] For many people, care funded by Title X is the only health care they can seek. In 2016, approximately 60% of patients sampled in a survey reported that a Title X health center was their only source of health care in the previous year.[30]

Community health centers funded through the **Health Center Program** provide essential primary care to all who need it, regardless of ability to pay. For 60 years, federally-funded health centers have connected communities to low-cost, high-quality, comprehensive dental, medical, and mental health services; they now serve more than 32 million people.[31] These are essential safety net providers: 67% of

[27] Maunnamalai ¶¶36–37, 43–48; McFalls ¶¶37–51; Morrison-Frichtl ¶¶31, 37–42; Ryan ¶¶57–59.
[28] Phil Killewald et al., Off. of Population Affs., Off. of the Assistant Sec'y for Health, U.S. Dep't of Health & Hum. Servs., Family Planning Annual Report: 2023 National Summary (Sept. 2024) (hereinafter "2023 FPAR"), https://opa.hhs.gov/sites/default/files/2024-10/2023-FPAR-National-Summary-Report.pdf.
[29] Off. of the Assistant Sec'y for Plan. & Evaluation, U.S. Dep't of Health & Human Servs., *Poverty Guidelines*, https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (last visited Aug. 7, 2025).
[30] Managi Lord-Biggers & Amy Friedrich-Karnik, *Features and Benefits of the Title X Program*, Guttmacher Institute (Feb. 2025), https://www.guttmacher.org/fact-sheet/features-and-benefits-title-x-program.
[31] Bureau of Primary Health Care, Health Resources & Servs. Admin., *Health Centers: A Guide for Patients* (July 2025), https://bphc.hrsa.gov/sites/default/files/bphc/about/health-center-handout.pdf.

health center patients in 2024 were at or below the federal poverty line,[32] 18% were uninsured,[33] and 28% were best served in a language other than English.[34] Like Title X, this program is often the only lifeline for millions who have effectively no other options for quality, affordable health care. Reinterpreting "federal public benefit" to newly encompass Title X providers and community health centers will cause devastating harm to individuals, to the public health, and to the health care delivery systems on which countless people (including citizens and others with legal status) rely.

The Directive denies essential health care to a broad range of undocumented and lawfully present members of our communities who already face substantial barriers to accessing preventive services. The health consequences of such barriers are severe. For instance, undocumented immigrants already experience higher rates of unintended pregnancy,[35] less adequate, timely, and regular access to prenatal care,[36] and delays in Pap tests to detect and prevent cervical cancer, mammograms, and clinical breast exams.[37] By directly barring undocumented immigrants as well as millions of individuals with legal status from accessing community health centers and Title X providers, the Directive will dramatically compound the barriers that immigrants and others face in accessing contraception, prenatal care, cancer screenings, STI testing and treatment, vaccines, diabetes management, well-child visits, and innumerable other critical health services — with reverberating health harms for both the excluded individuals and their families and communities.

In short, the Directive's attacks on Title X and the Health Center Program threatens to gravely undermine the health of millions of individuals and jeopardize population-level health across the country.

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[32] Health Res. & Servs. Admin., *National Health Center Program Uniform Data System (UDS) Awardee Data*, https://data.hrsa.gov/tools/data-reporting/program-data/national (last accessed Aug. 12, 2025) (click "Patient Characteristics" under "UDS Data Five-Year Summary ").
[33] *Id*.
[34] *Id*.
[35] Melissa Thomas & Esperanza Igram, *Beliefs and Practices of Contraceptive Usage among Undocumented Latina Women in Central Ohio*, 21 Annals Fam. Med. 4137 (2023), https://doi.org/10.1370/afm.21.s1.4137.
[36] Derrick M. Chu et al., *Cohort Analysis of Immigrant Rhetoric on Timely and Regular Access of Prenatal Care,* 133 Obstetrics & Gynecology 117, 117–28 (2019), https://doi.org/10.1097/aog.0000000000003023; Emily Welder et al., *Providing Prenatal Care for Patients with Limited Medical Insurance Coverage* 47 J. Cmty. Health 974, 974–80 (2022), https://doi.org/10.1007/s10900-022-01133-0.
[37] Adriana M. Reyes & Patricia Y. Miranda, *Trends in Cancer Screening by Citizenship and Health Insurance*, *2000–2010* 17 J. Immigr. & Minority Health 644, 644–51 (2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4561545/.

3. HHS' Restrictions would impose particular and disproportionate harms to people with disabilities.

The Directive's harms fall disproportionately on people with disabilities. The United States is home to over 70 million people with disabilities. Adults with disabilities are 2.5 times more likely to be living below the federal poverty line than adults without disabilities.[38] And among working age adults with disabilities 44% live below 200% of the federal poverty level. People with disabilities are more than twice as likely to experience homelessness and roughly half of all unhoused individuals live with an intellectual or physical disability. Not surprisingly, people with disabilities are twice as likely to report unmet healthcare needs due to cost.[39]

Because of these disproportionate economic and health vulnerabilities, many of the community-based programs newly restricted under PRWORA will cause outsized harm to people with disabilities, their families, and the communities they live in. These harms extend beyond the already severe impacts from restrictions in Title X and Community Health Centers, to target programs that specifically serve people with mental health disabilities, dual diagnoses, and substance use disorders.

One example is the **PATH** program (**Projects for Assistance in Transition from Homelessness**) which serves homeless people with serious mental illness — an extraordinarily vulnerable population.[40] PATH delivers services seldom available in mainstream mental health programs, including outreach, case management and housing assistance."[41] These supports benefit both the individuals, and the broader public, making the streets cleaner, safer, and healthier. Yet, many unhoused people — especially those with serious mental illness — would face serious barriers providing proof of citizenship or immigration status. Most struggle to maintain even basic forms of identification, let alone proof of their immigration or citizenship status.[42] Requiring proof of immigration status before engaging with a person on the street who is in psychiatric crisis would undermine PATH's ability to operate effectively and contradicts its community health mission.

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[38] Center for Research on Disability, *Section 6: Poverty - Compendium (2025)*, https://www.researchondisability.org/annual-disability-statistics-collection/2025-compendium-table-contents/section-6-poverty-compendium-2025 (last accessed Aug. 12, 2025).
[39] Cydnee Parsley, *Advancing Care for People with Disabilities in Community Health* Centers, Nat'l Ass'n of Comm. Health Centers (July 25, 2025), https://www.nachc.org/advancing-care-for-people-with-disabilities-in-community-health-centers/ (last accessed Aug. 12, 2025).
[40] Substance Abuse and Mental Health Servs. Admin., *Projects for Assistance in Transition from Homelessness (PATH)* (last updated Dec. 12, 2023), https://www.samhsa.gov/communities/homelessness-programs-resources/grants/path.
[41] *Id*.
[42] U.S. Government Accountability Office, *Homelessness: Barriers to Obtaining ID and Assistance Provided to Help Gain Access* (Feb. 7, 2024), https://www.gao.gov/products/gao-24-105435#:~:text=Further%2C%20people%20experiencing%20homelessness%20may,increase%20the%20risk%20of%20fraud.

Similarly, the **Community Mental Health Services Block Grant** funds state programs that serve adults and children with complex and serious mental health disabilities.[43] These grants support screening, outpatient and emergency services, and day treatment — programs that address complex needs and yield broad public benefits. Restricting access based on immigration status will disrupt care for some of the most vulnerable members of our communities.[44]

Other newly restricted programs serve people with addictions and dual diagnoses — mental health and substance use disorders.

For example, the **Substance Use, Prevention, Treatment, and Recovery Services Block Grant (SUPTRS)** funds to prevention and treatment programs, with a focus on high need populations, include pregnant women, people with HIV/AIDS, and people at risk of tuberculosis.[45] It provides treatment services for 2 million people in this country,[46] including medication treatment for opioid use disorder, an intervention shown to cut opioid overdose mortality in half.[47] SUPTRS is widely recognized as "the cornerstone of States' substance use disorder prevention, treatment, and recovery systems."[48] In the midst of a deadly overdose epidemic, inserting immigration verification requirements will delay or deny lifesaving care.

Certified Community Behavioral Health Clinics (CCBHCs) offer critical, low-barrier, community-based mental health and substance use disorder treatment to people in their own communities across the country. These clinics serve an estimated 3 million people, including those with serious mental illness and substance abuse disorders. Congress authorized the program in recognition of the reality that only 45% of adults with any mental health condition, and only 10% of adults with substance use disorder in the United States receive treatment.[49]

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[43] Substance Abuse and Mental Health Servs. Admin., *Community Mental Health Services Block Grant* (last updated Apr. 4, 2023), https://www.samhsa.gov/grants/block-grants/mhbg.
[44] *Id*.
[45] Substance Abuse and Mental Health Servs. Admin., *Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)* (last updated Apr. 24, 2023), https://www.samhsa.gov/grants/block-grants/subg.
[46] Nat'l Ass'n of State Alcohol and Abuse Directors, *Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant*, https://nasadad.org/substance-use-prevention-treatment-and-recovery-services-suptrs-block-grant/ (last accessed Aug. 12, 2025).
[47] National Academies of Sciences, Engineering, and Medicine, Medications for Opioid Use Disorder Save Lives 39 (Alan I. Leshner & Michelle Mancher eds., 2019).
[48] Nat'l Ass'n of State Alcohol and Drug Agency Directors, *supra* note 46.https://nasadad.org/substance-use-prevention-treatment-and-recovery-services-suptrs-block-grant/
[49] Substance Abuse and Mental Health Servs. Admin., *Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2021*, at 2 (2021), https://aspe.hhs.gov/sites/default/files/documents/78a7efd59c9c5f93cc5e243d69865e6a/ccbhc-rtc-21.pdf.

CCBHCs offer quick access to a range of care, including medication for addiction treatment, and medications for opioid use disorder, where quick access can mean the difference between life and death.[50] In many communities, CCBHCs offer the only alternative to emergency rooms and the criminal justice system — places both less effective and more expensive — as sources of care for people in crisis.[51]

Imposing immigration verification requirements will only push people — U.S. citizens and immigrants of all statuses — toward emergency rooms and, in the absence of treatment, could place them at risk of being incarcerated. At a time when this administration is issuing Executive Orders to lock up and institutionalize unhoused people with mental disabilities[52] — an extreme deprivation of civil liberties — it is particularly cruel that the administration is simultaneously making it harder to access some of the few voluntary, community programs that would allow people to avoid institutionalization.

The harms of these restrictions extend beyond immigrants. Some disabilities can cause people to struggle to be organized and keep track of paperwork. Requiring these individuals with disabilities to produce paperwork to prove their status to receive lifesaving services is yet another barrier to desperately needed care, even for qualified immigrants who would be eligible for these programs under the new HHS directive. Such residents may have lost paperwork via sweeps of encampments, or struggle to organize or keep track of important documents. Requiring a person experiencing a mental health or substance use crisis to bring the right documentation when they make the brave and difficult choice to seek treatment will result in programs turning away many people who are in fact citizens and "qualified" immigrants.

In addition to misconstruing PRWORA's definition of federal public benefit to include these community-based programs, HHS fails to justify why the public interest is served or fully consider the consequences of imposing immigration restrictions on these programs. It serves no one's interest to deny such care to anyone based on their immigration status; and the restrictions also impose burdens and barriers on service providers and citizens seeking needed care.

The Directive also includes foreboding language signaling that additional unnamed programs may also be considered "federal public benefits," creating uncertainty that presumably furthers this administration's maximalist immigration enforcement and deterrence policy, even where such uncertainty undermines public health. This Directive and the approach it adopts opens the door to additional unlawful and misguided designations, leading advocates for people with substance abuse disorders and other disabilities to ask, "what's next?" and whether any program is off limits. Will HHS

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[50] Critically, most clinics provide medication for addiction treatment within a week of when it is requested, in some cases on the same day. *See* Nat'l Council for Mental Wellbeing, *2024 CCBHC Impact Report* at 16 (June 3, 2024), https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/.

[51] Substance Abuse & Mental Health Servs. Admin., *supra* note 40, at 2.

[52] Ending Crime and Disorder on America's Streets, Exec. Order No. 14321, 90 Fed. Reg. 35817 (July 24, 2025).

decide that advancing a mass deportation agenda more important than reducing overdose deaths through State Opioid Response grants**,** which fund the purchase of opioid overdose reversal medications like naloxone?

4. **HHS' Restrictions would disproportionately harm survivors of gender-based violence, the vast majority of whom are women.**

In addition to the programs discussed above, HHS' restrictions on **Community Services Block Grant (CSBG) programs** raise particular concerns for survivors of gender-based violence and their families. The CSBG program funds to states, territories, and tribes to administer support services, such as crisis and emergency services, that alleviate the causes and conditions of poverty in under-resourced communities, including survivors of domestic violence and their children.[53] CSBG-funded programs have provided critical and lifesaving services and supports to survivors of domestic violence and their families, and are directly related to the prevention and reduction of domestic violence.[54] Domestic violence is a leading cause of homelessness for women, as well as for their children and families.[55] Nearly half of unhoused school-aged children and 29 percent of unhoused children under five reported having witnessed domestic violence in their own families.[56]

HHS' Directive will Cause a Chilling Effect that Harms Immigrants who Remain Eligible

The Directive's chilling effect will also diminish access to critical health care for millions of PRWORA-qualified individuals, including mixed-status families and households, as well as eligible immigrants who are fearful or confused about whether seeking healthcare might now expose them to immigration enforcement activities and other governmental retaliation. This is no hypothetical concern. For instance, US Census Bureau data from 2016–2019 — when the first Trump administration's "public charge" rule was in effect — indicated that enrollment in essential programs like Medicaid, the Children's Health Insurance Program, and the Supplemental Nutrition Assistance Program declined almost twice as fast among *U.S.-citizen children* with noncitizen household members as it did among children with only citizens in their households.[57]

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[53] U.S. Dep't of Health & Human Servs., *CSBG DCL Domestic Violence Awareness Month: Opportunities for Prevention and Action* (Oct. 22, 2014), https://acf.gov/ocs/policy-guidance/csbg-dcl-domestic-violence-awareness-month-opportunities-prevention-and-action.
[54] *Id.*
[55] Danielle Chiaramonte et al., *Examining contextual influences on the service needs of homeless and unstably housed domestic violence survivors*, 50 Journal of Community Psychology 4 (June 19, 2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8684560/.
[56] American Civil Liberties Union, Women's Rights Project, *Domestic Violence and Homelessness*, https://www.aclu.org/sites/default/files/pdfs/dvhomelessness032106.pdf (last visited Aug. 12, 2025).
[57] Randy Capps et al., *Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families*, Migration Policy Institute (Dec. 2020), https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real.

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Conclusion

For the foregoing reasons, the ACLU urges HHS to withdraw this Directive. If you have any questions about this comment or the accompanying materials, please contact Ming-Qi Chu, Deputy Director for the ACLU Women's Rights Project, at mchu@aclu.org or Jonathan Blazer, ACLU Director of Border Strategies, at blazerj@aclu.org.

Sincerely,

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EXHIBIT 1

The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER/TO POSTPONE EFFECTIVE DATE OF AGENCY ACTION

NOTE ON MOTION CALENDAR: July 21, 2025

ORAL ARGUMENT REQUESTED

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INTRODUCTION

For the first time since Congress created Head Start in 1965, the Department of Health and Human Services ("HHS") seeks to exclude children based on immigration status from participation in this early childhood education program, depriving hundreds of thousands of young children with life-altering opportunity. On July 14, 2025, HHS issued a directive, effective immediately, that purports to reinterpret the phrase "federal public benefit" in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to include Head Start and thereby exclude all "non-qualified" immigrants ("Immigrant Exclusion Directive" or "Directive"). U.S. Dep't of Health & Hum. Servs., Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit," 90 Fed. Reg. 31232 (July 14, 2025). The Directive abruptly reverses the HHS interpretation of "federal public benefit" issued shortly after PRWORA's enactment and followed for the past 27 years.

Timed just as enrollment for most Head Start programs begins, the Directive inflicts maximal and immediate harm on Plaintiffs. Immigrant families, regardless of actual status, will predictably forgo participation in Head Start, leading to devastating harms for agencies and the children they serve. Agencies, which must certify compliance with all terms and conditions under the False Claims Act, currently face the risk of legal liability because the Directive went into effect "immediately."

The Directive continues Defendants' unlawful attempt to hobble the Head Start program. HHS's stated goal to "ensure enrollment in Head Start is reserved for American citizens"[1] cannot be reconciled with Congress's purpose in the Head Start Act to ensure school readiness for children from immigrant communities. PRWORA itself makes clear that restricted "federal public benefits" like "welfare" do not include early education programs like Head Start.

Defendants' sudden reinterpretation of PRWORA also violates the procedural

[1] U.S. Dep't of Health & Hum. Servs., *HHS Bans Illegal Aliens from Accessing its Taxpayer-Funded Programs* (July 10, 2025), https://www.hhs.gov/press-room/prwora-hhs-bans-illegal-aliens-accessing-taxpayer-funded-programs.html.

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requirements of the Head Start Act and the Administrative Procedures Act, is arbitrary, and willfully disregards the enormous, short- and long-term harms for families who will lose access to Head Start. Notably, HHS deprived the public of the right to comment on the impact of regulation before allowing the Directive to take effect. Such systematic indifference to the consequences for immigrant children, families, and communities is not only cruel, but illegal.

On July 15, 2025, Plaintiffs filed a motion to amend their First Amended Complaint to add additional claims arising from the July 14, 2025, Immigrant Exclusion Directive. While Plaintiffs' prior motion for a preliminary injunction seeking relief for Defendants' DEIA Ban and Mass Cuts to the Office of Head Start is currently pending, Plaintiffs now move for a Temporary Restraining Order solely based on and seeking emergency relief for these new claims. For the reasons below, Plaintiffs request that the Court grant their motion.[2]

STATUTORY AND REGULATORY BACKGROUND

HHS's unprecedented redefinition of "federal public benefits" to include community-based early education programs like Head Start is contrary to the text and purpose of PRWORA as reflected in decades of consistent agency interpretation.

Enacted in 1996, PRWORA, Pub. L. No. 104-193, 110 Stat. 2105 (1996), limits eligibility for certain "federal public benefits" to "qualified" immigrants, 8 U.S.C. §§ 1611(a)-(c). "Qualified" immigrants are defined in *id.* § 1641 to include lawful permanent residents, refugees, asylees, and other enumerated immigrants. All non-citizens who do not fall within the definition—including many lawfully residing, including, for example, Special Immigrant Juveniles, U visa holders, students visa holders—are unqualified. PRWORA defines "federal public benefits" as:

> (A) any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States;

[2] Plaintiffs respectfully request that the Court schedule a hearing as soon as possible and provide, at minimum, one day's notice for an in person hearing to enable counsel to travel from out of town.

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> and (B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States.

Id. § 1611(c)(1). Under the PRWORA, "nonprofit charitable organizations" are not required to determine or verify eligibility, even when they are providing federal public benefits. *Id.* § 1642(d).

HHS's longstanding interpretation of "federal public benefits." HHS issued an interpretation of "federal public benefit" in 1998, within two years of PRWORA's passage. This interpretation remained consistent for 27 years until Defendants' Directive. As HHS explained in its original interpretation:

> Although the litany of categories in 401(c)(1)(B) is broad, it is not comprehensive and clearly excludes certain categories from the definition. For example, by explicitly identifying "postsecondary education" the statute excludes non-postsecondary education programs, such as Head Start and elementary and secondary education.

Dep't of Health & Hum. Servs., Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA): Interpretation of ''Federal Public Benefit,'' 63 Fed. Reg. 41658 (Aug. 4, 1998); s*ee also* Dep't of Health & Hum. Servs., Admin. for Child. & Fams., Off. of Child Care, *Clarification of Interpretation of "Federal Public Benefit" Regarding Child Care and Development Fund (CCDF) Services* (Nov. 25, 1998), https://acf.gov/occ/policy-guidance/clarification-interpretation-federal-public-benefit-regarding-ccdf-services ("Head Start and Early Head Start have been determined not to provide "Federal public benefits" because non-post secondary education benefits were expressly omitted from the statutory definition in title IV of [PRWORA]. Therefore, Head Start providers are not required to implement PRWORAs verification requirements."); Child Care and Development Fund (CCDF) Program, 81 Fed. Reg. 67438, 67461 (Sept. 30, 2016) ("when a child receives Early Head Start or Head Start services

that are supported by CCDF funds and subject to the Head Start Performance Standards, the PRWORA verification requirements do not apply."); *see also* Program Integrity and Institutional Quality: Distance Education and Return of Title IV, HEA Funds, 90 Fed. Reg. 470, 491 (2025) (reaffirming position that "programs that provide non-postsecondary services from the requirements of PRWORA, such as Head Start and elementary and secondary education" are not subject to restrictions under PRWORA).

Additionally, HHS and DOJ have consistently interpreted "federal public benefit" to exclude "benefits that are generally targeted to communities[.]" PRWORA; Interpretation of "Federal Public Benefit", 63 Fed. Reg. 41658, 41659 (Aug. 4, 1998); Dep't of Just., *Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, 62 Fed. Reg. 61344, 61361 (Nov. 17, 1997) (explaining even when a "community organization" receives a federal public benefit, if it uses the funds to provide a benefit to the community, "the prohibition would not apply.").

The Immigrant Exclusion Directive. On July 14, 2025, HHS issued the Immigrant Exclusion Directive reinterpreting the phrase "federal public benefit" in PRWORA to exclude "unqualified" immigrants from Head Start programs for the first time, effective immediately. 90 Fed. Reg. at 31232, 31236.

Despite HHS's previous explanation that PRWORA's explicit inclusion of "postsecondary education" in the list of "federal public benefits" means that the statute excluded non-postsecondary education programs like Head Start, its new Directive declares Head Start a "similar benefit" to "welfare," such that it falls within PRWORA's definition of "federal public benefit" and requires exclusion of "unqualified" immigrants. *Id.* at 31236. The Directive does not specify whether this new exclusion is based on the immigration status of the child, parents, guardians, or family and/or household members.

Further, while the Directive purports not to "formally revise" PRWORA's "verification requirements," which exempt nonprofit charitable organizations, the Directive also extensively

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references President Trump's January 20 and February 19 Anti-Immigration Executive Orders, and states that it is "the policy of this country that persons' access to public benefits should turn on those persons' immigration status." 90 Fed. Reg. at 31237. The Directive instructs entities, including HSA Plaintiffs' members, to "pay heed to the clear expressions of national policy," with no explanation of the nature or extent of this obligation, how entities are expected to implement the policy, or the consequences of noncompliance. *Id.*

The Directive acknowledges that it will have a significant economic impact and is subject to the requirements of Executive Orders 12866 and 13563, which direct agencies "to assess all benefits and costs of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits." 90 Fed. Reg. at 31238. To meet these requirements HHS issued a Regulatory Impact Analysis. *See* Exec. Secretariat, Immediate Off. of the Sec'y, Dep't of Health & Hum. Servs., *Final Regulatory Impact Analysis*, Docket No. AHRQ-2025-0002 (2025) [hereinafter *RIA*].

The RIA describes "full compliance with the notice" as one in which immigration status relating to every Head Start participant is verified such that no "unqualified" child is enrolled. *Id.* at 8, 14. Notably, although the Directive does not specify whose immigration status must be verified, the RIA refers to immigration status for both children and parents. *Id.* at 7-8. Defendants "anticipate that approximately 115,000 Head Start children and families could be impacted, or about 16% of total cumulative enrollment in Head Start programs in FY 2024[,]" and that approximately 500,000 children would no longer be eligible to attend Head Start. *Id.* at 7-8.

Head Start agencies, which are required to certify their full compliance under the threat of False Claims Act penalties, currently face real legal jeopardy if they do not change their procedures because the Directive went into effect "immediately."

LEGAL STANDARD

The temporary restraining order standard is "substantially identical" to the preliminary injunction standard. *Washington v. Trump*, 847 F.3d 1151, 1159 n.3 (9th Cir. 2017); *see also* Fed. R. Civ. P. 65(b). The APA also authorizes courts to "preserve status or rights pending conclusion

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of the review proceedings," 5 U.S.C. § 705, under the same standard as a preliminary injunction, *Immigrant Defs. Law Ctr. v. Noem*, No. 25-2581, 2025 WL 2017247, at *1 (9th Cir. July 18, 2025). Plaintiffs satisfy these requirements because the Directive changes the status quo in a way that will cause them irreparable injury, they are "likely to succeed on the merits," "the balance of equities tips in [their] favor," and "an injunction is in the public interest." *Winter v. Nat'l Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

ARGUMENT

I. Plaintiffs Face Irreparable Harm Because of the Immigrant Exclusion Directive.

The Directive seeks to bar over 500,000 children from Head Start programs, resulting in imminent and irreparable injuries to Head Start children, families, agencies and the organizations that support them. Children and families, including Parent Plaintiffs' members, will suffer irreparable harm through deprivation of access to early education with attendant economic, social, and public health consequences for parents, families, and communities. In addition, Head Start agencies, including HSA Plaintiffs and their members, will suffer drops in enrollment, resulting in funding cuts, layoffs, and even program closures, and the threat of civil and criminal penalties if they fail to comply with the vague Directive. Such irreparable injuries necessitate emergency relief. *See E. Bay Sanctuary Covenant v. Biden*, 993 F.3d 640, 677-79 (9th Cir. 2021).

A. Harms to Parent Plaintiffs' Members and Other Immigrant Families

The Directive will cause Head Start children and families, including Parent Plaintiffs' members to suffer loss of access to early childhood education and care.[3] Defendants' own analysis estimates the Directive's effect as excluding hundreds of thousands of children from Head Start.[4] Those estimates do not account for the predictable and intended broader chilling effect on even "qualified" immigrant families. Defendants' public statements about the Directive, including that

[3] Doutherd ¶¶26-31; Maunnamali ¶¶38-42; McFalls ¶¶24-36; Morrison-Frichtl ¶¶32-36; Ryan ¶¶26-34, 54-56; Williams ¶¶33-39.

[4] *RIA* at 7-8.

"Head Start is reserved for American citizens from now on,"[5] communicates that immigrants are not permitted in Head Start programs. The Directive will thus chill participation in Head Start even by "qualified" immigrant families both because of confusion about eligibility and fear that continued participation will subject them to increased scrutiny, adverse immigration consequences, and even civil and criminal penalties.[6] This same chilling effect has been well documented in other federal programs.[7]

For Parent Plaintiffs' members, loss of access to Head Start means sudden and major disruptions to their children's early childhood education, including critical dual language instruction, disability-related supports, and a safe and stable learning environment.[8] *See Doe v. Noem*, No. 2:25-cv-00633-DGE, 2025 WL 1141279, at *8 (W.D. Wash. Apr. 17, 2025) (disruption of educational programs or progress constitutes irreparable harm); *see also Tully v. Orr*, 608 F. Supp. 1222, 1225–26 (E.D.N.Y. 1985) (same). Such disruptions at a young age will have severe immediate and long-term harms to children's development, physical and mental health, self-esteem, sense of stability, and overall well-being.[9] These harms are especially devastating for children who have disabilities, are experiencing developmental delays, or are

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[5] U.S. Dep't of Health & Hum. Servs., *HHS Bans Illegal Aliens from Accessing its Taxpayer-Funded Programs* (July 10, 2025), https://www.hhs.gov/press-room/prwora-hhs-bans-illegal-aliens-accessing-taxpayer-funded-programs.html ("Head Start is among the programs included in the updated and expanded list of classified 'Federal public benefits' under PRWORA to *ensure enrollment in Head Start is reserved for American citizens from now on*.") (emphasis added).

[6] Doutherd ¶¶27-28; Maunnamalai ¶¶31-35, 38, 41-42; McFalls ¶¶33-36; Morrison-Frichtl ¶¶23-29; Ryan ¶¶26-34; Williams ¶¶34-36.

[7] Randy Capps et al., *Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflect Steep Decline in Benefits Use by Immigrant Families*, Migration Policy Institute (Dec. 2020), https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real; Jennifer M. Haley et al., *One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit Receipt in 2019*, Urban Institute (June 18, 2020), https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019; Neeraj Kaushal & Robert Kaestner,*Welfare Reform and Health Insurance of Immigrants*, 40 HSR: Health Services Research 3, 697-722 (June 2005), https://pmc.ncbi.nlm.nih.gov/articles/PMC1361164/.

[8] Doutherd ¶29; Maunnamalai ¶¶38-40; McFalls ¶¶26-29; Morrison-Frichtl ¶¶13, 33; Ryan ¶¶54-56; Williams ¶37.

[9] Doutherd ¶¶29-30; Maunnamalai ¶¶38-40; McFalls ¶¶26-29; Morrison-Frichtl ¶¶32-34; Ryan ¶¶54-56; Williams ¶¶37-38.

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otherwise vulnerable, because their families especially rely on Head Start programs for education-related supports and interventions.[10]

Without access to Head Start's early education and care, many of Parent Plaintiffs' members from immigrant families will be forced to miss work, risking losing their jobs, and drop out of school and training programs, which, in turn, jeopardizes their ability to pay rent and utilities, buy groceries, cover medical costs, and otherwise support their families.[11] *See Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1068 (9th Cir. 2014) (loss of opportunity to pursue professional opportunities constitutes irreparable harm) (quoting *Enyart v. Nat'l Conf. of Bar Examiners, Inc.*, 630 F.3d 1153, 1165 (9th Cir. 2011)); *J.L. v. Cissna*, 341 F. Supp. 3d 1048, 1069 (N.D. Cal. 2018) (same). These impacts are especially severe for immigrant mothers and families, who already face increased barriers to accessing early education programs that are affordable and/or linguistically and culturally appropriate.[12] The sudden disruption of these programs may even lead to housing insecurity and homelessness for some of Parent Plaintiffs' members.[13] These harms also will extend beyond impacted children and families, with collateral economic, social, and public health costs for employers, educational and vocational programs, and communities.[14]

For Parent Plaintiffs, the Immigrant Exclusion Directive further frustrates their mission to increase access to early education and care, forces them to divert limited time and resources toward rapid response efforts related to the Directive's impacts, and directly interferes with their ability to carry out core activities by impairing members' ability to attend and participate in programming due to lack of childcare.[15] Indeed, Parent Plaintiffs have already experienced

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[10] *Id.*

[11] *Id*.

[12] *How to Advance Immigrant Women's Access to Childcare: Policy Brief*, Upwardly Global (Feb. 15, 2024), https://www.upwardlyglobal.org/news/news/how-to-advance-immigrant-womens-access-to-childcare-policy-brief/; *see also* Williams ¶¶20-21.

[13] Doutherd ¶30; Williams ¶38.

[14] Zaslow Decl. ISO Pls. Mot. Preliminary Injunction, Doc. 51 ¶¶58–61; *see also* McFalls ¶29.

[15] Doutherd ¶¶32-37; Williams ¶¶40-46.

increased outreach from members, partners, and stakeholders regarding the Directive and its impacts in their communities.[16]

B. HSA Plaintiffs: Harms to Head Start Programs

HSA Plaintiffs and their members will also suffer irreparable harms because of the Immigrant Exclusion Directive.

The sudden reversal of Head Start's longstanding policy not to screen based on immigration status will immediately impact many of HSA Plaintiffs' members who are currently in the process of enrolling children and families for the upcoming school year.[17] A significant proportion of current enrollees are from immigrant families and communities to whom HSA Plaintiffs' members have devoted significant resources in a decades-long outreach and recruitment effort, including building community trust in Head Start as a safe and inclusive learning environment for their children.[18] HSA Plaintiffs' members anticipate that the Directive will result in drops in enrollment as high as 30 percent.[19] Indeed, HSA Plaintiffs and their members are already experiencing an increase in concerns and questions from families about the impact of the Directive.[20]

Because enrollment numbers are the source of Head Start funds, HSA Plaintiffs and their members face loss of funding as enrollment and attendance fall.[21] *See* 42 U.S.C. 9836a(h) (requiring monthly reporting on "actual enrollment"). As a result, thousands of Head Start teachers and staff are at risk of losing their jobs, and HSA Plaintiffs' members could be forced to close altogether.[22] Head Start programs that remain operational will face significant challenges recruiting and retaining students and staff, as they will be unable to recruit from the same

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[16] Doutherd ¶33; Williams ¶¶43-44.

[17] Maunnamalai ¶¶36-37; Morrison-Frichtl ¶¶18, 23; Ryan ¶34.

[18] Maunnamalai ¶¶17, 21, 31, 33, 34-35, 37, 44; McFalls ¶¶6, 35; Morrison-Frichtl ¶¶13-14, 24-25, 31-36; Ryan ¶¶29-30.

[19] Maunnamalai ¶¶34-35, 45; McFalls ¶¶25-27; Morrison-Frichtl ¶¶23, 26-29, 32; Ryan ¶28.

[20] Maunnamalai ¶¶31, 44; McFalls ¶51; Ryan ¶¶35-36, 58; Morrison-Frichtl ¶27.

[21] Maunnamalai ¶36, McFalls ¶¶25-32, 41, 47-48; Morrison-Frichtl ¶30; Ryan ¶¶38-39, 41-44.

[22] *Id.*

communities or to maintain stable budgets for staff and programming.[23] Indeed, even an enrollment decrease of just a few children could result in the loss of a Head Start teacher.[24] Thus, *all* Head Start children and families—not only those excluded by the Directive—will suffer as a result of programs' loss of funding and related consequences, particularly in communities where Head Start is the only available option for early childhood education and care.[25]

HSA Plaintiffs and their members also face significant harms because of the Directive's failure to provide clear guidance and standards on how to implement its restrictions, including whether eligibility determinations are based on the immigration status of the child, parents and/or guardians, or household and family members, and the Directive's warning that even agencies otherwise exempt from verification requirements must "heed" the new "national policy" of immigrant exclusion.[26] The Directive's failure to provide clear enforcement standards leaves HSA Plaintiffs' members unjustly vulnerable to legal consequences,[27] including civil and criminal liability under the False Claims Act. *See Am. Trucking Ass'ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1058 (9th Cir. 2009) (finding irreparable harm where Plaintiffs were forced to choose between complying with a potentially unconstitutional concession agreement and losing professional opportunities).

The Directive further harms HSA Plaintiffs and their members by frustrating their mission and mandate to support and provide early childhood education and care to low-income children and families in their communities.[28] In addition to the potential reduction of funding for HSA

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[23] Morrison-Frichtl ¶31; Ryan ¶¶40, 42; Maunnamalai ¶33; McFalls ¶¶35, 37, 40, 49.

[24] Maunnamalai ¶43.

[25] Morrison-Frichtl ¶30; Maunnamalai ¶¶17-18, 36; McFalls ¶¶45, 49; Ryan ¶¶38, 44.

[26] Maunnamalai ¶¶27-30; Morrison-Frichtl ¶¶19-22; Ryan ¶¶51-53; McFalls ¶¶20-23

[27] *See* 45 C.F.R. § 1303.3 (enumerating "HHS regulations that apply to all grants made under the Act"); 45 C.F.R. § 75.213 (subject to debarment); 2 C.F.R. § 180.800 (causes for debarment); *see also* 45 C.F.R. § 1304.5(a)(2)(iv) ("fail[ure] to comply with eligibility requirements" is grounds for terminate financial assistance to a Head Start agency); U.S. Dep't of Health & Hum. Servs., *Financial Assistance General Certifications and Representations*, https://www.hhs.gov/sites/default/files/financial-assistance-general-certification-representations.pdf (last visited July 20, 2025) (requiring compliance with "all applicable requirements of all other federal laws, executive orders, regulations, and public policies governing financial assistance awards").

[28] Maunnamalai ¶¶36-37, 43-48; McFalls ¶¶37-51; Morrison-Frichtl ¶¶31, 37-42; Ryan ¶¶57-59.

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Plaintiffs' members as a result of decreased enrollment and attendance,[29] HSA Plaintiffs and their members will be forced to divert resources to developing and implementing new policies and procedures for screening and verifying immigration status, as well as providing relevant training to all personnel.[30] Such increased costs, on top of the loss of funding and staff, will result in financial hardship to programs, forcing them to reduce services or close.[31]

II. Plaintiffs are Likely to Succeed on the Merits Because the Directive Violates the APA.

Plaintiffs will succeed on the merits of their claims that the Immigrant Exclusion Directive violates the APA because it is contrary to law, arbitrary and capricious, and fails to follow procedures required by law.

The Directive is a "final agency action[,]" 5 U.S.C. § 704, because it is a formal directive that reflects a consummation of decision-making and from which legal obligations and consequences will flow. *See Bennett v. Spear*, 520 U.S. 154, 177–78 (1997); *see also Or. Nat. Desert Ass'n v. U.S. Forest Serv.*, 465 F.3d 977, 982-83 (9th Cir. 2006).

A. Defendants' Directive Violates the APA because it is Contrary to Law and in Excess of Statutory Authority.

The Directive violates the APA because it conflicts with the text of PRWORA and Head Start Act. HHS claims that Head Start is a "federal public benefit" because it falls within the meaning of "welfare" or a "similar benefit." 90 Fed. Reg. at 31236. But this interpretation is impermissible for several reasons: (1) it conflicts with the clear text of PRWORA "definition of federal public benefit," which excludes early and elementary education and programs that provide services at the community, not individual, level; (2) the text and context of PRWORA make clear that "welfare" has a narrow meaning that encompasses only individualized cash benefits; and (3) the Directive's exclusion of "unqualified" immigrant children adds eligibility criteria inconsistent

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[29] Maunnamalai ¶¶23-26, 30-33; McFalls ¶¶33-36, 40-41, 47-49; Morrison-Frichtl ¶¶15-18, 22-25; Ryan ¶¶40-41; 59.

[30] Maunnamalai ¶¶26, 45-46; Morrison-Frichtl ¶¶18, 38-40; McFalls ¶38; Ryan ¶¶48-49; *see also* 45 C.F.R. § 1302.12(l)-(m).

[31] Ryan ¶44; Maunnamalai ¶¶47-48; Morrison-Frichtl ¶¶41-42; McFalls ¶¶31, 38.

with those in the Head Start Act, reauthorized almost a decade after PRWORA. "[A]pplying all relevant interpretive tools," the Directive's interpretation of PRWORA's definition of federal public benefit "is not the best" so "it is not permissible." *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 400 (2024).

1. Head Start is a Non-Postsecondary Education Program for the Community, which is not within PRWORA's Definition of "Federal Public Benefit."

PRWORA's definition of "federal public benefit" limits its scope (1) to enumerated categories of benefits and (2) whether those benefits are "provided to an individual, household, or family eligibility unit." 8 U.S.C. § 1611(c)(1)(B). Both textual limitations independently exclude Head Start.[32]

i. PRWORA Excludes Non-Postsecondary Education.

PRWORA's explicit listing of "postsecondary education" means that non-postsecondary education, including Head Start, is excluded. "The doctrine of *expressio unius est exclusio alterius* as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions." *Silvers v. Sony Pictures Ent., Inc.*, 402 F.3d 881, 885 (9th Cir. 2005) (en banc) (internal citation omitted). If Congress intended to include non-postsecondary education in the definition, it "would have been much easier (and much more natural)" to use the word "education," instead of the more specific, "postsecondary education." *See Bruesewitz v. Wyeth LLC*, 562 U.S. 223, 232 (2011). The use of the narrower postsecondary term is a "deliberate choice, not inadvertence*." Id.* at 233 (quoting *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168 (2003). The Directive impermissibly substitutes a term Congress did not choose to use in its legislative text. *See CC/Devas (Mauritius) Ltd. v. Antrix Corp.*, 145 S. Ct. 1572, 1581 (2025).

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[32] The Directive does not argue that Head Start is a "federal public benefit" under subsection (A), *id.* § 1611(c)(1)(A), nor could they. Head Start rants are provided to agencies. 42 U.S.C. § 9833, and thus not to any "alien who is not a qualified alien."8 U.S.C. § 1611(a).

Defendants admit that Head Start is a non-postsecondary education program. *See* 90 Fed. Reg. at 31236 ("an HHS program that deals with non-postsecondary education (such as Head Start)"). As Congress wrote in its reauthorization of Head Start through the "Improving Head Start *for School Readiness Act* of 2007," Pub. L. No. 110-134, § 2, 121 Stat. 1363, 1363 (2007) (emphasis added), "[i]t is *the* purpose of this subchapter to promote the school readiness of low-income children[.]" 42 U.S.C. § 9831 (emphasis added); *see also* Statement by President George W. Bush Upon Signing, 2007 U.S.C.C.A.N. S17 (2007) ("Stronger educational performance standards and an emphasis on research-based curricula and classroom practices will increase children's preparedness for school.") The Head Start Act's many provisions aimed at school readiness further confirm that Head Start is an education program. Like other education programs, Head Start agencies use evidence-based curriculum and instruction,[33] align with educational standards,[34] employ qualified educators who meet licensure requirements[35] and receive ongoing professional development,[36] and engage in ongoing assessment.[37] Because Head Start is an education program, Congress requires that if federal education funds are spent on early childhood education, the program must comply with the performance standards established by the Head Start Act, 20 U.S.C. § 6312(c)(7).

From the beginning, Head Start reflected its creators' insight that to successfully "prepare our neediest children for kindergarten and first grade," preschool was the "centerpiece" but it must be accompanied by health care and parent involvement in order to provide "children with

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[33] 42 U.S.C. § 9837(f)(3) (requiring "research-based early childhood curriculum" that "promotes young children's school readiness"); *id.* § 9836a(a)(1)(B) (requiring that children develop and demonstrate language, literacy, mathematics, science, cognitive abilities, social problem solving, among others).

[34] *Id.* § 9837(f)(3)(E) (requiring curriculum to be "aligned with the Head Start Child Outcomes Framework … and, as appropriate, State early learning standards"); § 9836a(a)(1)(B) (same); *see also id* § 9837a (requiring agencies "coordinate with the local educational agency serving the community").

[35] *Id.* §§ 9843a(a)-(b) (professional and degree requirements for classroom teachers, education coordinators and "mentor teachers").

[36] *Id.* § 9843a(a)(5) (requiring "classroom-focused" professional development every year); *see also* § 9832(21)(G).

[37] *Id.* § 9837(f)(3)(C) (requiring curriculum be "linked to ongoing assessment, with developmental and learning goals and measurable objectives"); *id.* § 9837(f)(5) (requiring "use research-based assessment methods" to "support the educational instruction and school readiness"); *see also id.* § 9836a(b)(3)(A)(i) *id.* § 9836a(c)(2)(F).

the building blocks they need to enter school ready to learn." 153 Cong. Rec. S14375-02 (Nov. 14, 2007) (statement of Sen. Edward M. Kennedy). Thus, the "provision to low-income children and their families of health, educational, nutritional, social, and other services that are determined, based on family needs assessments, to be necessary" is in support of the school readiness purpose, just as "a learning environment that supports children's growth in language, literacy, mathematics, science, social and emotional functioning, creative arts, physical skills, and approaches to learning" supports the educational purpose of Head Start. 42 U.S.C. § 9831; *contra* 90 Fed. Reg. at 31236 (taking quote out of context); *see also* 42 U.S.C. § 9833 (authorizing Secretary to provide financial assistance to Head Start programs that "will provide such comprehensive health, education, parental involvement, nutritional, social, and other services *as will enable* the children to attain their full potential and *attain school readiness*" (emphasis added)).

Head Start also does not fall into the general "catch-all" provision of "federal public benefit." Because Congress specifically excluded non-postsecondary education from the definition of "federal public benefit," the inclusion of catch-all language cannot override this more specific textual exclusion. *See RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012). Under the "well established canon of statutory interpretation…the specific governs the general." *Id*. (internal quotation marks and citation omitted).

ii. PRWORA Also Excludes Programs Delivering Services at the Community-Level.

Head Start is also outside PRWORA's limitation to those programs "for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States." 8 U.S.C. § 1611(c)(1)(B). In Head Start, the "payments or assistance" provided by HHS and federally appropriated funds goes to organizations and local governments to deliver programs to communities within designated geographic areas, rather than individuals, households, or families. 42 U.S.C. § 9833 (financial assistance provided to designated agencies); *id.* § 9836 (agency must be "within a community" to be designated); *id.* § 9836(h) ("Community" defined as a particular geographic area "that provides

a suitable organizational base and possesses the commonality of interest needed to operate a Head Start program."); *id.* § 9836(d) (Secretary required to designate another agency to deliver the Head Start program in a community if original provider is not delivering a high-quality program); *id.* § 9837(c)(2)(D)(i) (Head Start agencies must be "responsive to community…needs"); *id.* § 9835(f) (agencies "develop locally designed or specialized service delivery models to address local community needs"); *id.* §§ 9837(b), (c), (e) (requiring community residents be involved in the design and implementation of the program and governance). Therefore, Head Start is excluded from the definition of "federal public benefit" on the independent basis that neither HHS nor appropriated funds of the United States provide payments or assistance directly to individuals, households, or family eligibility units.

This is confirmed by the Congressional Conference Report, which states that non-postsecondary education programs are not included in the definition of federal public benefit because the benefit is not provided to an individual, household, or family eligibility unit. *See* H.R. Rep. No. 104-725, at 380 (July 30, 1996) (Conf. Rep.) ("The intent of the conferees is that title I, part A of the Elementary and Secondary Education Act [20 U.S.C. 6311, et seq.] would not be affected by section 401 [8 U.S.C. 1611(a)] because the benefit is not provided to an individual, household, or family eligibility unit."); *see also Nw. Forest Res. Council v. Glickman*, 82 F.3d 825, 835 (9th Cir. 1996) ("[A] congressional conference report is recognized as the most reliable evidence of congressional intent because it represents the final statement of the terms agreed to by both houses." (internal quotation omitted)).

iii. Contemporaneous, Consistent Agency Interpretations Further Undermine Defendants' Interpretation.

"[I]nterpretations issued contemporaneously with the statute at issue, and which have remained consistent over time," "may be especially useful in determining the statute's meaning," and further support the conclusion that PRWORA's "federal public benefits" do not include Head Start. *Loper Bright Enters.*, 603 U.S. at 394 (citation omitted). HHS and DOJ interpreted "federal public benefit" just two years after PRWORA's passage to exclude Head Start and that remained

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consistent for 27 years until Defendants' issued this Directive. *See* 63 Fed. Reg. 41658; 90 Fed. Reg. 31232; *see also Rodriguez v. Bostock*, No. 3:25-cv-05240-TMC, 2025 WL 1193850, at *15 (W.D. Wash., Apr. 24, 2025) (finding contemporaneous agency interpretation and unchanged practice persuasive); *Org. of Pro. Aviculturists, Inc. v. U.S. Fish and Wildlife Serv.*, 130 F.4th 1307, 1319 (11th Cir. 2025) (finding agency interpretation issued two years after passage of statute and consistently applied for thirty years persuasive).

2. Head Start is Not Welfare or Anther Similar Benefit under PRWORA.

The Directive states that Head Start falls within PRWORA's definition of "federal public benefit" because it is "welfare…or other similar benefit" as it provides "health, educational, nutritional, and social and other services" or "child care" and is means tested. 90 Fed. Reg. at 31236. Defendants' interpretation is wrong. As used in PROWRA, the term "welfare" refers to reoccurring cash payments to low-income families with children, a benefit that Head Start does not provide.

Defendants' interpretation violates the rule against surplusage because the express inclusion of "health," "postsecondary education," and "food assistance" would be entirely unnecessary if "welfare…or other similar benefit" broadly encompassed all "health, educational, nutritional, and social and other services." 90 Fed. Reg. at 31236; *see also Nat'l Lab. Rels. Bd. v. Aakash, Inc.*, 58 F.4th 1099, 1105 (9th Cir. 2023) ("We generally interpret a statute to avoid making a part of it unnecessary") (citation omitted). The title of PRWORA that created 8 U.S.C. § 1611, "Restricting *Welfare and* Public Benefits for Aliens" (emphasis added), demonstrates that "welfare" has a separate meaning and is not the same as a "public benefit."

Defendants are also wrong that Head Start as "a similar program" to welfare because it "also provide[s] means-tested assistance to families and individuals." 90 Fed. Reg. at 31236. While being low-income is one eligibility criterion for Head Start, other criteria do not depend on family income. *See* 42 U.S.C. § 9840(a)(1)(B) (children residing in low-income communities, including children with disabilities); *id.* § 9840(a)(2) (rural communities); Pub. L. No. 118-47,

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Div. D, Title II, § 238, 138 Stat. 460, 681 (2024) (operated by an Indian tribe); *id.* § 239 (Migrant and Seasonal Head Start); 45 C.F.R. § 1302.12(c)(iv) (2016) (child is in foster care).

The text, context, and structure of PRWORA also support the conclusion that "welfare" refers specifically to Aid to Families with Dependent Children (AFDC), and its replacement, Temporary Assistance to Needy Families (TANF). *See K Mart Corp. v. Cartier, Inc.,* 486 U.S. 281, 291 (1988) ("In ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole.") (citation omitted). PRWORA uses the term "welfare" in several provisions, and each time it does so to refer to reoccurring cash payments for low-income families with children. *See* Pub. L. No. 104-193, § 114, 110 Stat. 2105, 2180 (1996) (defining "welfare reform effective date" to mean "the effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996," which is "Block Grants for Temporary Assistances for Needy Families."); *id.* § 403 (defining "welfare spending" by referencing the "total amount required to be paid to the State under former section 403 (as in effect during fiscal year 1994)"—that is, the payments to states under AFDC, 42 U.S.C. § 603 (1994); *id.* § 413(d)(1) (using the term "overall welfare caseload" to refer to "recipients of assistance under the State program" funded by TANF); *id.* § 101(8)(A) (Congressional findings that the longer a woman remains "on welfare," the higher the total AFDC costs). HHS has also long demonstrated its understanding of "welfare" as used in PRWORA to refer to its cash aid to families program. *Compare id.* § 107 (directing HHS to "study and analyze outcomes measures for evaluating the success of the States in moving individuals out of the *welfare* system through employment") (emphasis added) *with* ACF, ASPE, & HHS, *Report on Alternative Outcome Measures: Temporary Assistance for Needy Families (TANF) Block Gran*t (Nov. 30, 2000), https://aspe.hhs.gov/reports/report-alternative-outcome-measures-temporary-assistance-needy-families-tanf-block-grant (noting report is "submitted pursuant to section 107" of PRWORA and explaining that states show they have "moved families off welfare" by showing a decline in TANF caseloads).

The two sources Defendants cited in the Directive undermine rather than support the conclusion that Head Start is "welfare" or similar to it. The Welfare Indicators Act, which requires the Secretary of HHS to prepare an annual report "on welfare receipt in the United States[,]" 42 U.S.C. § 1314a(d)(1), does *not* classify Head Start as a "welfare" program. *Id.* § 1314a(d)(2). The Welfare Indicators Act also undercuts Defendants' claim that "child care" is similar to "welfare." The statute begins with a statement of "Congressional policy" that juxtaposes dependence on welfare programs, which the federal government should "reduce," *id.* § 1314a(a)(1), with "education" and "child care," which the federal government should support to assist families in achieving financial independence, *id.* § 1314a(a)(3).

Nor is Head Start "child welfare," *see* 90 Fed. Reg. at 31236, which refers to the programs that focus on preventing child abuse and neglect. *See* § 429A, 110 Stat. at 2277 (requiring study of "child welfare" meaning children at risk of or determined to have experienced abuse or neglect); *see also* 42 U.S.C. § 9843(b)(2) (Head Start Act provision requiring Secretary to "support training for personnel…providing services to children determined to be abused or neglected or children referred by or receiving child welfare services").

3. The Directive Creates a Conflict with the Head Start Act.

Defendants' Directive is also contrary to law because it creates a conflict between the text of PRWORA and the text of the Head Start Act, which establishes "criteria for eligibility," including children who "shall" be eligible, without regard to immigration status. 42 U.S.C. § 9840(a)(1)(B); *see also* 45 C.F.R. § 1302.12(c), (d). Defendants' re-interpretation of "federal public benefit" flatly contradicts Congress's direction that certain children "shall" be eligible for Head Start, and thus violates a cardinal rule of statutory interpretation: "to the extent that statutes can be harmonized, they should be[.]" *Hellon & Assocs., Inc. v. Phoenix Resort Corp.*, 958 F.2d 295, 297 (9th Cir. 1992). These two statutes have been read harmoniously for the last 27 years, during which time Congress amended the Head Start Act's provision on "criteria for eligibility" several times, and never added immigration status. *See* Pub. L. No. 105-285, Title I, § 112, 112 Stat. 2702, 2718-19 (1998); Pub. L. No. 110-134, § 14, 121 Stat. 1363, 1415 (2007); Pub. L. No.

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114-328, Div. A, Title VI, § 618(j), 130 Stat. 2000, 2161 (2016); *see* Pub. L. No. 118-47, §§ 238-39, 138 Stat. 460, 681 (2024). Congress's modification of Head Start's eligibility criteria without adding restrictions based on immigration status demonstrates Congress's approval of HHS's prior construction of "federal public benefit" to exclude Head Start. *See e.g. Grondal v. Mill Bay Members Ass'n, Inc.*, 471 F. Supp. 3d 1095, 1121 (E.D. Wash. 2020) *aff'd*, 21 F.4th 1140 (9th Cir. 2021) ("Congress ratifies an agency's interpretation or practice when it is aware of that interpretation or practice, legislates in an area covered by that interpretation or practice, and does not refer to or change that interpretation or practice.") (internal citation omitted).

Moreover, "[w]here two statutes conflict, the later-enacted, more specific provision generally governs." *United States v. Juvenile Male*, 670 F.3d 999, 1007–8 (9th Cir. 2012) (rejecting argument statutes "do not conflict because they each operate on different classes of individuals and agencies."); *see also Hellon*, 958 F.2d at 297. In reauthorizing the Head Start Act, Congress specifically proscribed who would be eligible for the particular program over a decade after more general proscription in PRWORA. This later, more specific eligibility criteria governs.

B. Defendants' Directive Is Arbitrary and Capricious in Violation of the APA.

The Immigrant Exclusion Directive is arbitrary and capricious because Defendants relied on improper factors, failed to consider important aspects of the issue, offered an explanation counter to the evidence, and based their decision on implausible reasoning. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

First, the Directive abandons decades of existing policy without meaningfully considering "important aspects of the problem," including the significant reliance interests of Head Start agencies, Parent Plaintiffs, and Head Start children and families. *See id.* at 43. Because HHS "was not writing on a blank slate [and] *was* required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns"—even where the asserted basis for the agency's action is to correct purported legal defects. *U.S. Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 591 U.S. 1, 33 (2020) (internal quotation marks and citation omitted).

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Because Defendants have made clear for decades that Head Start is not a "federal public benefit" under PRWORA, HSA Plaintiffs and their members have never screened participants based on immigration status, allowing staff to build the community trust necessary for program recruitment and retention.[38] Similarly, Parent Plaintiffs' members have relied on this policy to enroll their children in Head Start without fear of increased scrutiny of their immigration status or other negative repercussions.[39] The Directive now forces HSA Plaintiffs to abruptly change course in program implementation,[40] while disrupting critical access to early education and care for Parent Plaintiffs' members and their children.[41] Such disruptions have severe and lasting harms, especially for children with disabilities or who are otherwise vulnerable.[42] Because Defendants failed to weigh any of these significant reliance interests against competing policy concerns, the Directive is arbitrary and capricious. *Regents*, 591 U.S. at 33. *See also Immigrant Defs. Law Ctr.,* 2025 WL 2017247, at *11 ("Merely saying something was considered is not enough to show reasoned analysis.") (quotation omitted).

Moreover, despite acknowledging that the Directive will have a significant economic impact, 90 Fed. Reg. at 31238, Defendants have not meaningfully considered the significant costs and burdens that this Directive imposes on Head Start agencies, including tribes and school districts, that operate Head Start programs, and failed entirely to quantify or even acknowledge the economic, social, and health costs for impacted children and families. *See City & Cnty. of San Francisco v. U.S. Citizenship & Immigr. Servs.,* 408 F. Supp. 3d 1057, 1106 (N.D. Cal. 2019), *aff'd* 981 F.3d 742 (9th Cir. 2020) (failure to consider costs of disenrollment from benefits programs of Public Charge Rule was likely unlawful under APA); *see also Ctr. for Biological Diversity v. Bernhardt*, 982 F.3d 723, 750 (9th Cir. 2020) (finding agency action was arbitrary and

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[38] Doutherd ¶23; Maunnamalai ¶33; Morrison-Frichtl ¶25; Williams ¶28; Ryan ¶¶29-30; McFalls ¶35.
[39] Doutherd ¶¶18-23; Williams¶¶24-28.
[40] Maunnamalai ¶¶24-26; Morrison-Frichtl ¶¶16-18; Ryan ¶40; McFalls ¶40.
[41] Doutherd ¶¶26-31; Williams ¶¶33-39.
[42] Doutherd ¶¶29, 31; Williams ¶37; Ryan ¶54; McFalls ¶¶28, 45.

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capricious where agency failed to quantify impacts or to explain why it could not quantify impacts). The Directive will cut off access to early education for many of Parent Plaintiffs' members' children, which, as explained above, will inflict significant costs and hardships on parents, local businesses, schools, and beyond.[43] Yet, Defendants' RIA is devoid of any discussion or analysis of these cost. *RIA* at 14.

Defendants also failed to quantify or acknowledge the severe financial and programmatic impacts to Head Start agencies caused by sudden drops in attendance and enrollment,[44] the significant resources required to develop and implement new enrollment policies and procedures,[45] and diversion of limited staff and financial resources toward ensuring compliance with the Directive's requirements.[46] And while Defendants provide an estimate of the costs of collecting and reviewing documentation to verify eligibility, *RIA* at 12–14, these estimates do not account for the complexity involved in determining whether non-citizen participant is "qualified" under PRWORA, particularly for providers who have never been required to ask about or screen based on immigration status.

Additionally, because the Directive imposes restrictions on participation in Head Start programs without providing any guidance on how to comply with the requirements[47]—it leaves Head Start agencies, including HSA Plaintiffs' members, without standards for determining whether they are in compliance. *See Ariz. Cattle Growers' Ass'n v. U.S. Fish & Wildlife*, 273 F.3d 1229, 1233 (9th Cir. 2001) (holding agency action was arbitrary and capricious because it "issue[d] terms and conditions so vague as to preclude compliance therewith"). The lack of clear guidance, coupled with the Directive's threat to "pay heed to the clear expressions of national

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[43] *Id.;* Doutherd ¶¶26-31; Williams ¶¶33-39; *see also* Zaslow Decl. ISO Pls. Mot. Preliminary Injunction, Doc. 51 ¶¶58–61.

[44] Maunnamalai ¶¶31-37; Morrison-Frichtl ¶¶23-31; McFalls ¶¶31, 41, 47-48; Ryan ¶¶38-44, 49, 59; *see also* 42 U.S.C. § 9836a(h) ("Reduction of grants and redistribution of funds in case of underenrollment.").

[45] Maunnamalai ¶26; Morrison-Frichtl ¶18; Ryan ¶¶48-49; McFalls ¶¶38, 42; *see also* 45 C.F.R. § 1302.12.

[46] Maunnamalai ¶¶26, 37; Morrison-Frichtl ¶¶18, 31; Ryan ¶¶48-49; McFalls ¶¶ 38-39, 50.

[47] Maunnamalai ¶¶27-30; Morrison-Frichtl ¶¶19-22; McFalls ¶¶20-22; 50; Ryan ¶¶51-53.

policy,"[48] leave HSA Plaintiffs' members at "unfettered discretion" of HHS, with "no method by which the [programs] can gauge their performance" or compliance. *Ariz. Cattle Growers'*, 273 F.3d at 1250.

Accordingly, Plaintiffs are likely to succeed on their claim that the Immigrant Exclusion Directive is arbitrary and capricious in violation of the APA.

C. Defendants Failed to Follow Procedures Required by Law.

HHS's issuance of the Directive, which took immediate effect, violates the procedural requirements of the Head Start Act and the APA. Each deficiency is sufficient to establish that HHS failed to observe necessary procedures required by law and must be set aside. 5 U.S.C. § 706(2)(D).

Head Start Act. The Head Start Act requires HHS to "prescribe eligibility for the participation of persons in Head Start programs" "by regulation." 42 U.S.C. § 9840(a)(1)(A). Such regulations must be published in the Federal Register at least 30 days before they take effect. *Id.* § 9839(d). Because current regulations governing eligibility for Head Start do not include requirements related to immigration status, *see* 45 C.F.R. § 1302 *et seq.*, HHS cannot radically alter the eligibility criteria without providing the public an opportunity to explain the devastating impacts of such a change.

Furthermore, before HHS may make "any" modifications to Head Start program "performance standards," including any "administrative" standards, the Secretary must consult a range of stakeholders (including experts in early childhood education and AIAN programs), assess the educational impacts based on enumerated considerations, and ensure that "revisions in the standards will not result in the elimination of or any reduction in quality, scope, or types" of Head Start services. 42 U.S.C. §§ 9836a(a)(1)-(2). The Directive fails to establish that any of these prerequisites have been met.

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[48] 90 Fed. Reg. at 31237.

APA Notice and Comment Requirement. Under the APA, agencies must publish proposed rules and allow the public an opportunity to comment. 5 U.S.C. § 553(c). "The greater the public interest in a rule, the greater reason to allow the public to participate in its formation." *E. Bay Sanctuary Covenant v. Barr*, 385 F. Supp. 3d 922, 947-48 (N.D. Cal. 2019) (quoting *Hoctor v. U.S. Dep't of Agric.*, 82 F.3d 165, 171 (7th Cir. 1996) (Posner, J.)). Because the Directive creates new "rights [and] duties" for Head Start participants by imposing a categorical bar to eligibility for any "unqualified" immigrant it is "properly considered to be a legislative rule" subject to the APA's notice and comment requirement. *Gen. Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984); *see also Elec. Privacy Info. Ctr. v. U.S. Dep't of Homeland Sec.*, 653 F.3d 1, 6-7 (D.C. Cir. 2011) (a legislative rule "effects 'a substantive regulatory change' to the statutory or regulatory regime") (quoting *U.S. Telecom Ass'n v. F.C.C.*, 400 F.3d 29, 34–40 (D.C. Cir. 2005)).

HHS effectively concedes that the Directive requires notice and comment but argues that the Directive must take effect before the 30-day comment period concludes because "any delay would be contrary to the public interest," and therefore good cause exists for the rule to take immediate effect. 90 Fed. Reg. at 31238. But HHS does not meet the standard for invoking the "good cause" exception. *U.S. v. Valverde*, 628 F.3d 1159, 1164 (9th Cir. 2010) (an agency "must overcome a high bar if it seeks to invoke the good cause exception to bypass the notice and comment requirement."). The exception is an "emergency procedure" that must be "narrowly construed and only reluctantly countenanced." *E. Bay Sanctuary Covenant v. Trump*, 909 F.3d 1219, 1253 (9th Cir. 2018) (*E. Bay* II) (internal quotation marks and citation omitted). The Ninth Circuit has recognized that good cause exists only "where [an] agency cannot 'both follow [notice and comment requirements] and execute its statutory duties'" or where 'delay would do real harm' to life, property, or public safety.' *California v. Azar*, 911 F.3d 558, 576 (9th Cir. 2018) (internal citations omitted).

HHS does not meet this narrow standard. The Directive states that "additional delay to correct the deficiencies of the 1998 Notice would fail to remove incentives to illegal immigration that are exacerbating the invasion at the Southern Border," and references one "report" that

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addresses immigration trends generally from 2020 to 2024. 90 Fed. Reg. at 31238. But HHS cites no evidence *linking* participation in early education programs like Head Start to increased immigration of any form, lawful or unlawful. Its claim that these programs are an incentive for immigration and that a 30-day delay in the effective date will "exacerbate the invasion" are far too "speculative" to support a finding of good cause. *E. Bay II*, 909 F.3d at 1253 (government failed to establish good cause where there was no evidence that delay in effective date would "would give aliens a reason to 'surge' across the southern border in numbers greater than is currently the case").

III. The Balance of Equities and Public Interest Strongly Favor Injunctive Relief and a Stay of the Agency Directive.

The balance of equities and public interest heavily favor Plaintiffs. *See Nken v. Holder*, 556 U.S. 418, 435 (2009) (courts consider these factors jointly when plaintiffs seek emergency relief against the government).

In stark contrast to the irreparable and severe harm to Plaintiffs, *see supra* I, Defendants will suffer no harm, much less irreparable harm, from Head Start continuing under the rules that have been in effect for nearly three decades. Any alleged harm to Defendants pales in comparison to the magnitude of "preventable human suffering" that would result if this Court permits the Directive to remain in effect. *Golden Gate Rest. Ass'n v. City & Cty. of San Francisco*, 512 F.3d 1112, 1126 (9th Cir. 2008) (internal quotation marks and citation omitted).

Granting a TRO and/or stay under 5 U.S.C. § 705 while litigation is pending will serve the public interest by ensuring Defendants' compliance with the law and preventing harm to the immigrant communities targeted by the Directive and all present and future participants of Head Start. "Our society as a whole suffers when we neglect the poor, the hungry, the disabled, or when we deprive them of their rights or privileges." *Lopez v. Heckler*, 713 F.2d 1432, 1437 (9th Cir. 1983). Conversely, continuing the education of young people has a clear benefit to the public. *Clifton v. Pearson Educ., Inc.*, No. 5:11-cv-03640-EJD, 2012 WL 1565236, at *11 (N.D. Cal. May 2, 2012) (recognizing an "overwhelming public interest in education."). *E. Bay Sanctuary*

Covenant, 993 F.3d at 681 (citation omitted) ("[W]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated.")).

Thus, the balance of equities and the public interest weigh decisively in Plaintiffs' favor.

CONCLUSION

The Court should grant the motion and postpone the effective date of the Directive and/or temporarily enjoin Defendants from enforcing it until the Court can further consider the merits. The Court should exercise its discretion to waive or set a nominal bond.

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The undersigned certifies that this motion contains 8,392 words, in compliance with the Local Civil Rules.

Dated: July 21, 2025

Respectfully submitted,

By: /s/ La Rond Baker

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The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

DECLARATION OF CLARISSA DOUTHERD IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER/TO POSTPONE EFFECTIVE DATE OF AGENCY ACTION

NOTE ON MOTION CALENDAR: July 21, 2025

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I, Clarissa Doutherd, hereby declare and state as follows:

1. I am over eighteen years old, and I have personal knowledge of the facts set forth in this Declaration. I could and would testify competently to those facts if called as a witness in this case.[1]

I. Parent Voices Oakland's Mission and Activities

2. I am the Executive Director of Parent Voices Oakland ("PVO"). I have served as the Executive Director since 2013. Prior to serving as Executive Director, I served as a PVO community organizer, working closely with parents and families to advance access to high-quality, affordable, and accessible early childhood education and childcare.

3. In addition to my professional experience and background, I am a Black mother of a son and have personal knowledge of and experience with navigating the early education and childcare system as a low-income single parent. In fact, I was first introduced to PVO's work while in the process of seeking a childcare subsidy for my family in California. I have direct knowledge of the Head Start enrollment process, as well as the many barriers to accessing childcare and early education in the Bay Area.

4. PVO is a parent-led non-profit organization that organizes, educates, and advocates for affordable, accessible, and quality early education and childcare for families, and particularly low-income families of color, in Oakland and the surrounding Bay Area in California. PVO's multi-racial, multi-lingual, and multi-generational membership includes parents and caregivers in Oakland and the surrounding Bay Area. As discussed further below, many of our members are immigrants and/or have children and family members who are immigrants, including those who have children currently enrolled in Head Start programs.

5. The mission of PVO is to make quality, accessible, and affordable early childhood education and childcare available to all families, and to organize, support, and empower parents and caregivers in becoming life-long advocates for their children. PVO's

[1] I incorporate by reference my Declaration in Support of Plaintiffs' Motion for Preliminary Injunction, filed on May 16, 2025.

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programs are developed to expand local, state, and federal resources for an early education and childcare delivery system that is comprehensive and community driven, and that provides support for children and families universally. Through community organizing, parent education and leadership development, coalition building, and civic engagement, PVO elevates the visibility of low-wage workers, and particularly Black workers and other workers of color, who cannot afford the full cost of childcare and early education.

6. In addition to my position as Executive Director, PVO has staff members dedicated to carrying out its activities and supporting its mission and goals. PVO has a Director of Operations; Director of Organizing; a Parent Advocacy Coordinator; and two Community Organizers.

7. PVO maintains an organizational structure designed to center and uplift the voices and perspectives of parents and caregivers, including those from historically marginalized backgrounds. For example, PVO has a base of parent leaders and organizers who have direct knowledge of and experience with the early education and childcare system in Oakland and the surrounding Bay Area. PVO is in constant contact with its parent, caregiver, and childcare provider members in various ways, including, but not limited to, monthly parent and caregiver membership meetings, one-on-one meetings with parent and caregiver members on a weekly basis, coalition meetings (including monthly committee meetings with parents and agencies), community workshops, direct actions and rallies, and other meetings and events.

8. PVO runs an organizing fellowship program, where parents learn community organizing skills, receive education on healthcare and childcare systems, and engage in outreach to their neighborhoods, schools, child development centers, and places of worship. PVO also has volunteers who support its events, including parent policy forums, door-to-door outreach, and tabling at community events.

9. As discussed above, PVO has a significant number of members who are immigrants and/or have children and household members who are immigrants, including many

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who have limited English proficiency. PVO works to ensure that these members have access to its programming and activities through providing translation and interpretation services. For example, PVO provides live translation services in multiple different languages at the vast majority of its meetings, trainings, and other programming to ensure that its immigrant members and other members with limited English proficiency are able to participate fully. In addition, PVO retains translation services to ensure that its written materials and resources are accessible in other languages for its members.

10. PVO currently has three campaigns, including (1) Save Head Start, in which PVO is taking action to demand that the future of Head Start is secured and shaped by directly impacted parents and workers; (2) Voices for Health Justice, in which PVO is fighting to identify and address root causes of health inequities and disproportionately high infant mortality rates for Black families; and (3) Protect Public Education, in which PVO is calling on elected leaders to commit to policy and budget solutions for quality early education for children, and especially Black children and other children of color.

11. In 2024 alone, PVO trained over 240 parent leaders, and secured pledges from over 1,000 Alameda County families to fight for increased access to affordable early education and childcare. Moreover, through its organizing and outreach efforts, PVO staff and members reached over 23,800 community members by phone and text banks, knocked on over 1,300 doors, and had over 760 conversations with Oakland residents.

12. Through its efforts, PVO has helped to secure $14.4 million dollars in general purpose funding to sustain and expand Oakland Head Start programs, protected 52 Head Start jobs, and saved three Head Start sites from closure.

II. Parent Voices Oakland's Immigrant Membership and Reliance on Head Start

13. Access to Head Start is critically important for low-income immigrant children and families in Oakland and the surrounding Bay Area, including many of our members who rely on Head Start to ensure that their children have access to early childhood education.

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14. This is especially true in Alameda County, where Oakland is located. According to the Vera Institute of Justice,[2] one in three Alameda County residents are immigrants, and four in seven children in Alameda County have at least one immigrant parent. Immigrant children and their families are a substantial and essential part of the community, workforce, and economy in Alameda County.

15. Many of our members who are immigrants and/or have immigrant children and family members rely on Head Start for early childhood education. In particular, they rely on the inclusive and culturally and linguistically appropriate early education and related resources provided by Head Start programs, such as dual-language curriculum and learning materials, interpretation services during meetings and events, translated books and take-home materials, and early language development resources. These resources are critically important to ensuring adequate access to early childhood education and learning, a strong connection and partnership between home and school, effective communication with parents and caregivers about children's learning and development, and children's early language development in English and their home languages.

16. These members also rely on Head Start for a safe and inclusive educational environment for their children to develop their skills and knowledge, play with other children, and learn from and interact with other trusted adults. Head Start programs are essential to children's learning and development, as well as their sense of stability and belonging. This is especially true for children who have disabilities, who are experiencing developmental delays or challenges, and who are navigating housing insecurity, trauma, or other forms of instability.

17. Head Start programs also allow PVO's parent and caregiver members, including those who are immigrants and/or have immigrant children and family members, to go to work, attend school or job training, attend medical appointments for themselves or their

[2] Vera Institute of Justice, *Profile of immigrants in Alameda County, California* (Mar. 2025), https://vera-institute.files.svdcdn.com/production/downloads/publications/Alameda_County_Immigrant_Population_Profile.pdf.

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other children and family members, go grocery shopping and prepare meals, and otherwise care for themselves and their families.

18. Based on my personal knowledge and experience working with PVO's parent and caregiver members, Head Start agencies, and other community stakeholders, it is my understanding that Head Start agencies have never screened for or even asked about the immigration statuses of children or their families when enrolling children in Head Start programs as a matter of policy. I have not heard of any instance, in our community or elsewhere, where a Head Start agency has denied services based on immigration status.

19. Our staff regularly speaks with parents and caregivers about Head Start and assists them with enrolling in and/or navigating Head Start programs. One of the most common questions we receive from them is whether enrollment in Head Start depends on immigration status. Our members often have concerns that enrollment in Head Start programs could lead to their information being shared with immigration enforcement or other law enforcement agencies, negatively impact their immigration status, or have other harmful consequences for themselves and their families.

20. Because of the Head Start program's policy of not screening enrollment based on immigration status, we have consistently been able to recommend Head Start as a quality early childcare education option to our immigrant parent and caregiver members during one-on-one meetings, membership meetings, and other programming.

21. Based on our understanding of Head Start's longstanding policy, we regularly inform our parent and caregiver members that Head Start agencies will not consider their immigration status, or the immigration statuses of their children and/or other family members, when enrolling their children into Head Start programs.

22. We also rely on and share information regarding Head Start's longstanding policy not to screen based on immigration status in PVO's community education programming and training.

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23. Head Start's policy not to screen based on immigration status has helped to build greater trust between our community members and Head Start agencies. Because of this policy, our parent and caregiver members are more willing to ask about and enroll their children in Head Start programs because they trust that doing so will not put their or their family members' immigration status at risk or under scrutiny.

III. The Immigrant Exclusion Directive and Its Impacts on Parent Voices Oakland

24. It is my understanding that on July 14, 2025, the U.S. Department of Health and Human Services ("HHS") published a new rule, titled "Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of 'Federal Public Benefit,'" which defines Head Start as a "federal public benefit" under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act and excludes certain immigrants from accessing Head Start based on their immigration status ("Immigrant Exclusion Directive"). It is my understanding that this Immigrant Exclusion Directive went into effect immediately.

25. It is also my understanding that the Immigrant Exclusion Directive does not provide any guidance or clarity on whether eligibility for Head Start programs will be determined based on the immigration status of the child, parents, guardians, and/or family and household members.

A. Harms to Parent Voices Oakland's Members

26. As a result of this new Immigrant Exclusion Directive, many immigrant children and families in Oakland and the surrounding Bay Area, including PVO's members, may lose access to Head Start's early childhood education programs, which is likely the only form of early education and childcare these immigrant families can access because of their socio-economic status.

27. In addition, the Immigrant Exclusion Directive will immediately scare many of our parent and caregiver members from enrolling or participating in Head Start's early

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childhood education programs out of confusion and fear that the Directive will have negative consequences for their children and their families.

28. Because of the Immigrant Exclusion Directive, many of our members who are immigrants and/or have immigrant children and family members fear that participation in Head Start will target them for immigration enforcement or even put them at risk for civil and criminal penalties. Families who previously relied on Head Start's policy not to screen based on immigration status now fear that participating in Head Start programs could put them or their loved ones at risk.

29. The sudden loss of access to Head Start's early childhood education programs would be devastating to their children's development and well-being at an age when early education can make the greatest difference. This disruption will be even more severe for children who have disabilities, children who are experiencing developmental delays, and children who are experiencing homelessness, housing insecurity, financial instability, or other trauma, who often rely on Head Start not only for early education, but also for structure, nourishment, and a safe, familiar environment where they can build trusting relationships with adults and other children and develop essential social, cognitive, and emotional skills.

30. In addition to disrupting early childhood education and learning, losing access to Head Start will have devastating economic, social, and health impacts on our parent and caregiver members and their families. Without access to Head Start, many of our members will be forced to miss work, reduce their work hours, lose their jobs entirely, miss classes, drop out of school, or miss out on professional and educational opportunities. Because of this, losing access to Head Start would jeopardize these members' economic security and ability to meet their families' basic needs, including by paying rent and utilities, buying groceries, diapers, and other basic necessities, or obtaining medicine and other medical care. This is especially true in the Bay Area, where the cost of private childcare is already unaffordable for most low-income families.

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31. When parents and caregivers are chilled from accessing and participating in Head Start, the consequences are immediate and serious: Their children lose access to early education and learning at a time when disruption is especially harmful to their development, and they lose the childcare support they need to work, study, and otherwise care for themselves and their families. The result is not only harmful to the individual children, parents, and households, but also to the broader systems of community support and trust that PVO works every day to build and maintain.

IV. Harms to Organization Based on Immigration Guidance

32. By threatening access to early education and childcare for immigrant and low-income families, the Immigrant Exclusion Directive directly undermines PVO's mission and efforts to expand high-quality, affordable, and equitable early childhood education and childcare for parents and caregivers in Oakland and the surrounding Bay Area. PVO's work is rooted in meeting the needs of families who face systemic barriers to care, including immigrant families, mixed immigration-status households, and those with limited English proficiency. Head Start has long been a cornerstone of that work.

33. In response to the Immigrant Exclusion Directive, PVO will be forced to divert limited staff capacity and financial resources away from our core activities toward rapid response efforts to address the Directive and its impacts. This includes responding to members' questions about eligibility, monitoring changes in Head Start enrollment practices, and helping immigrant members and their families navigate their early education options. In fact, we have already received and expended staff time responding to numerous inquiries from community members and stakeholders about the Directive and its impacts.

34. Because of the Directive, PVO staff will be forced to divert significant staff time and resources away from existing campaigns and activities toward developing communications and know-your-rights materials, hosting informational sessions and trainings for our members and stakeholders about the Directive, and organizing other actions and

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programs to combat the impacts of the Directive. These efforts come at the expense of other already-planned and critical work, including our health equity initiatives.

35. In addition to the staff time and resources expended on rapid response efforts, PVO will be forced to divert limited financial resources toward additional translation and interpretation services to ensure that such response efforts are accessible to immigrant members and their families who have limited English proficiency and/or speak other languages.

36. When families lose access to Head Start, they also lose a vital source of stability and support. The Directive will directly impair and interfere with PVO's core activities by making it significantly harder for our members to participate in meetings, programs, leadership development training, advocacy campaigns, and community gatherings. We also anticipate that we may lose some members altogether as a result of the Immigrant Exclusion Directive, because loss of access to Head Start will prevent and/or discourage many of our directly impacted members from being involved with PVO's activities, and may even cause some members to leave the region due to lack of other affordable and available early education and childcare options. Many of our most engaged parent and caregiver members are directly impacted by the Directive, and their absence jeopardizes the strength and reach of our organizing work, especially for our immigrant communities.

37. As a grassroots parent-led organization with a small staff and limited budget, PVO depends on strong relationships with families, early education providers, and local systems. The more families are excluded from Head Start, the more difficult it becomes for us to fulfill our mission, expand our membership, and maintain our operations. These harms extend beyond individual families and directly undermine the effectiveness and sustainability of our work.

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I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 21, 2025

/s/ *Clarissa Doutherd*

Clarissa Doutherd

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The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

DECLARATION OF JENNIE (MAUER) MAUNNAMALAI IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER/TO POSTPONE EFFECTIVE DATE OF AGENCY ACTION

NOTE ON MOTION CALENDAR: JULY 21, 2025

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I, Jennie (Mauer) Maunnamalai, hereby attest as follows:

I. Background

1. I am over eighteen years old, and I have personal knowledge of the facts set forth below. If called to testify about them, I could and would be able to do so competently. [1]

2. I am the Executive Director of the Wisconsin Head Start Association (Wisconsin HSA). I have served as Executive Director of Wisconsin HSA since 2020. Prior to serving as Wisconsin HSA's Executive Director, for five years I was the Head Start Collaboration Director at the Wisconsin Department of Public Instruction, where I served as a key connection between grantees and state initiatives and services that also support Head Start families. I hold a Master's degree in Public Affairs from the La Follette School of Public Affairs at the University of Wisconsin-Madison and a Bachelor's degree in Legal Studies and French.

3. Wisconsin HSA is a 501(c)(3) non-profit, non-partisan membership association of Wisconsin Head Start and Early Head Start grantees and delegate agencies that has been in existence for the last fifty years. Wisconsin HSA is made up of 39 grantee members who operate Head Start programs that provide early childhood education and support to families throughout Wisconsin. It serves all of Wisconsin's 72 counties, interacts with 424 school districts serving the state's children, and has approximately 280 center locations.

4. Wisconsin HSA's mission is to support and strengthen Head Start and Early Head Start programs for the benefit of children, families, and communities through advocacy, professional development, and strategic alliances. Its membership is open to each federally recognized Wisconsin Head Start and Early Head Start grantee and delegate agency. Members pay annual dues determined by the Wisconsin HSA Board of Directors. Members have access to a network of support, including training events and workforce support, leadership development, representation on statewide collaborative projects, management of state

[1] I also incorporate into this declaration the information contained in the declaration I submitted in support of Plaintiffs' Motion for a Preliminary Injunction, filed on May 26, 2025. ECF No. 39.

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supplemental Head Start grants, and advocacy work to assure the availability of comprehensive, top-quality services to families facing the struggles that living in poverty presents.

5. Wisconsin HSA's purpose is to gather and disseminate information about Head Start for its members, provide assistance to state, regional, and national Head Start agencies and organizations, and to advocate for and carry out activities that support educational goals for Wisconsin's children and their families.

6. Wisconsin HSA's Board is made up of directors, staff, and parents of Head Start, Early Head Start, Migrant and Seasonal Head Start, and Native American Early Head Start and Head Start programs in Wisconsin. Wisconsin HSA's Board maintains a comprehensive governance structure that ensures representation from all parts of its membership to ensure that Wisconsin HSA remains aligned with both the mission and priorities of its members and their broader communities, and responsive to their needs. The Board is both a fiduciary and a working Board, providing oversight on budget, collaborating with Association staff, and offering insight and oversight on advocacy and outreach efforts.

7. In my role as Executive Director of Wisconsin HSA, I aim to promote the goals of the Association's members while maintaining fiduciary responsibilities to the Board. I am responsible for overseeing operations and organizational management, including accounting and fiscal management; organizing professional development and networking events; conducting outreach and engagement activities with collaborative partners; directing advocacy and policy work at the local, state, and federal levels; and managing the Association's contracts and grants.

8. Consistent with Wisconsin HSA's mission, as well as the requirements of the Head Start Act and its implementing regulations, Wisconsin HSA is committed to serving and being responsive to the changing and developing needs of Wisconsin's children and families, including based on the needs identified in our members' annual Head Start mandated community assessments. Wisconsin HSA does this by offering a variety of services to

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members, including regular opportunities for Head Start management level staff to participate in training and networking in several key services areas; an annual training conference dedicated to innovative practical initiatives, programs, and applied research; training and technical assistance to develop content for the broader early childhood and care community in Wisconsin, including topics such as Practice Based Coaching, Class Observation Training, and a New Director Series; assistance with grant-related troubleshooting; and liaising and advocating with the Office of Head Start (OHS) on behalf of members.

9. Wisconsin HSA is in constant contact with its members in the following ways: hosting a weekly Zoom call for members, with guest speakers (e.g., representatives from the Regional Office) and opportunity for questions, feedback, and networking; regularly sending emails multiple times per week with updates on funding and policy issues; maintaining an active Facebook page for members to communicate with each other and Association staff; hosting an annual conference with professional development and networking opportunities; and providing regular virtual trainings on a variety of topics.

10. Wisconsin HSA is funded by membership dues, event revenue, event registration, and a small number of philanthropic grants. It has a full-time staff of two personnel, including myself and an administrative assistant.

II. Composition of Wisconsin Head Start Association Members

11. Wisconsin HSA's members include Head Start grantees that operate several different kinds of early childhood education programs, including Head Start, Early Head Start, Migrant and Seasonal Head Start, and Native American Early Head Start and Head Start programs in Wisconsin. Six of our members operate programs in local school districts, and three are city or state government agencies.

12. Through these programs, Wisconsin HSA's members provide comprehensive services for over 15,000 of Wisconsin's youngest and most vulnerable citizens, as well as their families. Wisconsin HSA members operate as independent non-profit organizations, within

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State school districts, and as part of community action agencies, alongside American Indian Tribes, and in partnership organizations serving migrant farmworker communities.

13. In 2024, Wisconsin HSA members received approximately $168 million in grants from the Administration of Children and Families, Office of Head Start within the U.S. Department of Health and Human Services to operate their Head Start programs, including to provide services to children and families and for continuing education, training and professional development like that provided by Wisconsin HSA. None of Wisconsin HSA members' grant funds go directly to any particular children or families.

14. Of the approximately 15,000 children served by Wisconsin HSA members, over 70 percent are children of color, including significant numbers of Latine, African American, American Indian, and refugee children. Wisconsin HSA members also serve over 1,797 children with disabilities, over 1,123 unhoused children, 512 foster children, and over 338 pregnant women.

15. We have one Wisconsin HSA member who operates a Migrant and Seasonal Head Start (MSHS) program, serving over 300 children and their families. Many of these families work in and around Wisconsin's dairy farms and other agricultural facilities, with a modified program calendar accommodating the unique needs of agricultural work. MSHS also provides continuity of services for children and families if and when they relocate between states over the course of an agricultural season.

16. Wisconsin HSA also has nine members who operate Tribal Head Start programs that serve over 1,000 children and their families. These programs serve descendants of the 11 federally recognized Indian Tribes in Wisconsin. Consistent with the Head Start Performance Standards, these members expend considerable resources on programs focused on cultural and language preservation, including language immersion classes.

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III. The Importance of Head Start for Wisconsin Communities

17. Over 70 percent of Head Start families have at least one parent working full-time, in job training, or pursuing their education, and they rely on Head Start to provide quality childcare as they seek to improve their financial stability. Head Start programs are particularly important in Wisconsin's rural and agricultural areas, including Western Wisconsin where the dairy farms are staffed by large numbers of Latino migrant and immigrant populations who are predominantly Spanish-speaking, and Northern Wisconsin which draws immigrant families for seasonal employment in agriculture and tourism. Head Start programs in these areas are often the only childcare facilities available to these populations and are essential to allowing parents – particularly mothers – to work reliable hours to support their families.

18. In many communities, Head Start may be the only (or only no-cost) early childcare option available to poor families. While the State offers some Supplemental Head Start grants, they could not replace the existing, federally funded Head Start program, and the supplemental grants only serve to expand the number of children that can be enrolled at these programs, or to improve the quality of services offered. The total amount of state funding available is a small fraction of federal Head Start funding for these programs, and many programs use the state supplement to support salaries and other program costs rather than to fund additional slots.

19. In addition to serving children and families, Head Start is a significant part of Wisconsin's thriving workforce. Some Head Start parents participate in the program as volunteers at first, then later find employment in Head Start classrooms. Head Start grants support a workforce in Wisconsin of 4,424 employees, 419 contract staff, and 9,537 volunteers, of whom 7,757 are Head Start parents.

20. Head Start programs also support local economies by purchasing food, classroom materials, and other goods from local businesses.

21. Wisconsin HSA members serve a significant number of migrant, immigrant and refugee children and families, and provide a variety of services to support their needs. The

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most prevalent need is for bilingual Spanish-speaking teachers and staff, and those with understanding of tribal cultures, customs and languages of the 11 federally recognized American Indian nations and tribal communities in the state. As such, and consistent with Head Start Performance Standards, the services they provide these communities include not only dual language curriculum for children, but they also spend considerable resources to provide dual language resources to families. Those resources include interpretation services during parent and family conferences, home visits, and parent engagement events; translated books and literacy take-home materials in multiple languages to strengthen the connection between home and school, and to support early language development in both English and the child's home language.

22. Wisconsin HSA members also support their diverse families through community engagement, resources and referral. In 2024, Wisconsin HSA members served over 14,000 families, including families with two parents, single fathers, pregnant women, foster parents, and grandparents. They offer services including English as a second language training; education on fetal development, prenatal/postpartum healthcare, and benefits of breastfeeding; help enrolling in education or job training programs; assistance to families with incarcerated individuals; parenting curriculum; and asset building services. In 2024, approximately 4,500 Head Start families received emergency or crisis intervention services, such as meeting immediate needs for food, clothing, or shelter. The same year, approximately 1,400 families also received housing assistance such as subsidies, utilities and repairs.

IV. Immigration Status has Never Been Required for Head Start Eligibility

23. As far as I know, the Head Start Act has never included immigration status as one of the eligibility criteria, and Wisconsin HSA members do not screen applicants' immigration status for purposes of enrollment or any other reason. Wisconsin HSA has come to rely on this practice, and requiring them to change it would be incredibly burdensome, and diminish enrollment for the reasons discussed here.

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24. Our members do not have the resources to verify immigration status for families. They are already burdened with various data collection obligations, including personal information of prospective enrollees and their families, for example: dates of birth, race and ethnicity, primary and secondary language, parent and guardian employment and education information, 12 months of income documentation, housing status, household member information, welfare benefits they may be receiving, health and medical history, etc..

25. The burden of collecting information for families experiencing homelessness is even greater. It is my understanding that federal law requires schools to remove barriers to enrollment, including dispensing with collection of documentation families do not readily have. And for children who are in foster care, Head Start providers often have no way of verifying immigration status based on the information available, given the lack of contact with their biological parents. Nevertheless, these children are wards of the state who are court-ordered to enroll in an early childhood program.

26. If Wisconsin HSA members were required to track and verify immigration status, the burden on the organization would be substantial and multifaceted, involving significant changes to staff, operations, data systems, and compliance protocols. Staff would need training to understand and accurately interpret a wide range of immigration documentation, which is highly complex and typically outside the scope of their expertise. The intake and enrollment process would become more time-consuming, potentially delaying services to children and families. Agencies would likely need to hire additional administrative or compliance personnel, including legal counsel, to ensure accurate classification and avoid unintentional violation of federal civil rights laws. From an IT standpoint, current systems would require upgrades or modifications to securely collect, verify, and store sensitive immigration data. These systems would also need to be compliant with federal data privacy standards, and capable of producing audit trails for federal oversight, which would involve additional costs and technical capacity.

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V. The Immigrant Exclusion Directive is Vague and Ambiguous

27. I am aware that on July 14, 2025, the Department of Health and Human Services published a Notice of Interpretation (the "Immigrant Exclusion Directive") of the term "federal public benefit" as used in the Personal Responsibility and Work Opportunity Reconciliation Act ("PWRORA"). I am unaware of any guidance I can provide to Wisconsin HSA members to help them comply with the terms of the Immigrant Exclusion Directive.

28. For example, I understand that under PRWORA, "nonprofit charitable organizations" do not have to verify the immigration status of applicants. However, other provisions of the Immigrant Exclusion Directive appear to conflict with this understanding. The Directive appears to emphasize that because PRWORA does not prohibit nonprofits from verifying immigration status, and appears to say agencies should do so in any event, *e.g.* warn that "all entities . . . should pay heed to the clear expression of national policy described above" - namely that certain immigrants should not have access to resources like Head Start. These confusing and ambiguous statements leave Wisconsin HSA nonprofits to decide at their potential peril whether to rely on the statutory exemption or face potential False Claims Act liability or other penalties if they do not voluntarily comply with the Directive.

29. Another ambiguity with the Immigrant Exclusion Directive is whether eligibility is based on the immigration status of the child, the parent or other family member, or both. This is a significant concern because, based on my understanding of the makeup of immigrant communities in the state, many are comprised of what is known as "mixed status" families, or those in which one or more family members may be undocumented or hold a temporary status, but the others are not. The information Wisconsin HSA members must already collect includes information that relates to the parents or household – e.g., income verification – to determine the eligibility of the child. It is unclear whether this information should still be collected, if simply having one undocumented income earner would itself be disqualifying.

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30. The timing of when immigration status screening must occur is also left ambiguous in the Immigrant Exclusion Directive. It says that the screening requirement is effective immediately, but it does not make clear if, when, and how often programs are required to start verifying the immigration status of children who are already enrolled. Currently, the Head Start Act only requires screening for eligibility once at the beginning of each program year, with that determination remaining valid for the succeeding program year. It is unclear whether the Directive requires additional screening for already enrolled children, which could pose serious challenges in advance of the upcoming school year.

VI. Wisconsin HSA Members Will be Harmed by the Immigrant Exclusion Directive

31. Wisconsin HSA members have reported declines in attendance among both Spanish-speaking and immigrant families, which they attribute to this Administration's Executive Orders directing agencies like HHS to deny "illegal aliens" access to federal resources, who fear immigration consequences if they continue participating in Head Start programs. Staff at Wisconsin HSA members have reported increased hesitation among some families about enrolling their children, attending parent meetings, or providing personal information. Some families have withdrawn or chosen not to re-enroll, citing concerns about government scrutiny or fear that their information could be used against them. Wisconsin HSA members anticipate that the Immigrant Exclusion Directive will intensify this trend, particularly now as they begin enrolling for the new school year.

32. The Directive also appears to be in conflict with the Head Start Act's mandate to prioritize enrollment of limited English proficient students, many of whom are likely the very students slated for exclusion by the Directive. Along the same lines, requiring program staff to inquire about and reject applicants based on their immigrant status will scare off even those participants who remain eligible. Families with eligible children will hesitate to enroll out of fear that participation will have consequences for the parents' or other family members' immigration status – for example, putting them at risk of being declared a "public charge" and impacting their ability to apply for permanent residency or citizenship.

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33. HHS' prior practice of not requiring agencies to verify the immigration status of enrollees had the important benefit of allowing families to access these crucial early childhood services without fear of unintended consequences. It also allowed the program staff to maintain trusting relationships with the families and communities they serve, which has been a key driver of recruiting and retaining enrollees, and working with families to ensure high quality and needs-based educational services.

34. Because Wisconsin HSA members have never verified immigration status, it is difficult to say with precision how many children and families will be impacted by the Immigrant Exclusion Directive. However, based on their understanding of the demographics of their locales, some Wisconsin HSA members anticipate their enrollment could decline by 30% or more – comprised of both undocumented families and those who may still be eligible but decide not to participate in Head Start for fear of negative consequences. One Wisconsin HSA member has already experienced a drop in attendance due to fear of immigration enforcement raids. This member runs a program that is designed to be neighborhood based and offers bus transportation. Because immigrant families often live in the same communities, this program anticipates that several of their sites would lose much of their enrollment. This creates a logistical problem, as they cannot easily transport children from other areas, while sites in other neighborhoods are already at maximum capacity and cannot absorb additional children.

35. Another Wisconsin HSA member estimates that at two of their sites, about 80% of the children belong to immigrant families, many of which may have members who are undocumented. They have observed increased stress and heightened levels of anxiety among their families in recent months, including families who were afraid to send their kids to Head Start. One of these program sites is located inside a local school, and requiring the program to verify immigration status – which is contrary to the school district's policy and practice – will impact their ability to collaborate effectively. Another Wisconsin HSA member that runs a school district-based program has had multiple families ask how the school will protect their children from ICE, and whether the school would release the children to ICE during a raid.

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This program has spent countless hours attempting to reassure parents that their children are safe, to preserve the trust and community relationships necessary to continue their work.

36. The Immigrant Exclusion Directive's negative impact on enrollment is particularly concerning given the Office of Head Start's recent announcement that it will be enforcing its "full enrollment initiative." The two together will make it difficult for Wisconsin HSA members to comply with the terms of their grants. If programs have their funds "recaptured" due to under-enrollment, they risk being forced to lay off staff, which will diminish the overall quality of services for all children the agency serves, particularly where the departing staff brought a needed linguistic or cultural competency. Under-enrollment by even just a few students could lead to the loss of an entire teaching position.

37. Moreover, Wisconsin HSA members have expressed concern that the Immigrant Exclusion Directive will require them to divert resources from their core mission of providing quality early childhood education to the most needy children, as they will be forced to divert time on mission-related work to further immigration screening efforts. Head Start program staff are not immigration officers; they are educators, family advocates, and child development specialists who work every day to ensure children are safe, healthy, and ready to learn. Being forced to engage in immigration screening has also raised valid concerns among Wisconsin HSA members that they may lose staff who would not be willing to compromise their relationships with families.

VII. The Immigrant Exclusion Directive Will Harm Children and Families

38. As discussed above, Wisconsin HSA members estimate that enrollment may decline by 30% or more due to this new policy. Taking into account the report that HHS estimates that about 16% of currently enrolled children will lose access to Head Start as a result of the Directive, this translates to at least 2,400 children and their families losing high quality early childhood education statewide.

39. In addition to loss of educational services, these immigrant children and families will also lose out on Head Start's important wrap around services, like developmental

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screenings, physical and mental health services, nutritious meals, and supports for children with disabilities, such as speech, occupational, and physical therapy.

40. Without a safe place to take their children during the workday, immigrant parents and families will be forced to miss work or school, or risk placing their children in unsafe environments so they can earn a livelihood for them. They will also be deprived of other Head Start resources directed at parents and caregivers as added support for the family unit, such as housing assistance, employment referrals, and parenting classes.

41. The absence of guidance and clarity about how the Directive will be implemented is completely untenable for immigrant families. For example, suppose a Head Start program does not screen for immigration status, or it does and incorrectly determines that a child is eligible. If the parents enroll their child, but later learn they don't qualify for services, will they still face immigration or other penalties?

42. Moreover, the Directive will also likely have the effect of scaring away even families that are "qualified aliens," because they fear participating in Head Start programs could later work against them, i.e. if they are deemed a "public charge," which could jeopardize their chances of being able to adjust to longer term immigration status.

VIII. The Immigrant Exclusion Directive Will Harm the Wisconsin HSA

43. The Directive will force the Wisconsin HSA to divert its focus away from its mission of providing continuing education, training, technical assistance, and advocacy related to core issues like the quality of curriculum and instruction on behalf of its members.

44. Wisconsin HSA's small staff and limited resources will be – and already have been – burdened by responding to the Immigrant Exclusion Directive, including attempting to address the understandable confusion and panic from members and the families they serve.

45. Wisconsin HSA will have to divert staff time and resources away from its usual core activities to instead advise its members on how to manage compliance with the new policy, including counseling their families and communities on what is now expected of them and what they must do to comply.

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46. This will mean Wisconsin HSA staff have less time and fewer resources to work on other critical issues, such as ongoing state-level advocacy, developing new projects and professional development opportunities, and pursuing funding opportunities.

47. Based on the reaction and information shared from Wisconsin HSA members so far, I anticipate that the Immigrant Exclusion Directive will also likely cause Wisconsin HSA to lose members, because the decline in enrollment may cause them to lose their grants, or because they are forced to reevaluate their budgets and eliminate Wisconsin HSA membership dues going forward.

48. For these reasons, there is a real possibility that Wisconsin HSA would have to reduce staff and drastically curtail the services it offers its members, or even cease operation, as the majority of its funding is paid for through dues from its members.

IX. Benefit of Enjoining the Immigrant Exclusion Directive

49. Enjoining the Immigrant Exclusion Directive would protect Wisconsin HSA and its members from expending significant time, money, and effort to address the confusion, panic, and misinformation it will cause to its immigrant families if the policy goes into effect.

50. A Temporary Restraining Order would allow Wisconsin HSA and its members to continue to serve the significant number of immigrant children and families in their respective locales, which they understand to be part of their mandate under the Head Start Act. They also will not need to experience loss of enrollment of these immigrant communities and thereby grant funds, or run afoul of the Directive and triggering False Claim Act liability.

51. A Temporary Restraining Order would protect children and families from the harms associated with the vague and ambiguous nature of the policy, which will likely result in many immigrant children and families being denied educational and wrap around services, even if they are "qualified" for them, because of misinformation about or misinterpretation of their particular immigration status, and whether or not they remain eligible for Head Start.

52. A Temporary Restraining Order will also counter the significant fear immigrant communities in Wisconsin are facing in response to the Directive, which is likely going to

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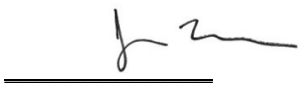
result in potentially "qualified" families disenrolling their children out of an abundance of caution so as not to face negative immigration consequences of continuing participation in Head Start.

Pursuant to 28 U.S.C. § 1786, I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 21, 2025



Jennie (Mauer) Maunnamalai

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The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

DECLARATION OF KARA MCFALLS IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER/TO POSTPONE EFFECTIVE DATE OF AGENCY ACTION

NOTE ON MOTION CALENDAR: JULY 21, 2025

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I, Kara McFalls, hereby declare and state:

1. The information in this declaration is true and correct to the best of my knowledge, and I am of majority age and competent to testify about the matters set forth herein.
2. I incorporate all of the facts and allegations contained in my first declaration submitted in this case in support of Plaintiffs' Motion for a Preliminary Injunction.

Experience and Professional Background

3. I am the Executive Director of the Pennsylvania Head Start Association ("Pennsylvania HSA"). I have served in this role since 2023. I oversee all operations of Pennsylvania HSA, including its funding and policy advocacy and professional development for Head Start program members. This includes offering training and professional development for the staff of member Head Start programs, and supporting member programs in meeting their obligations under the Head Start Act, Head Start Performance Standards, and related state laws and regulations.
4. I joined Pennsylvania HSA in 2018 as the Associate Executive Director. I became Executive Director in 2023 after serving as Interim Executive Director. Prior to joining Pennsylvania HSA, I developed curricula and professional development for early child learning from birth to age five, managed three Head Start agencies, led a non-profit early childhood program, and taught in public school. I hold a bachelor's degree in Child Development and Family Dynamics with Teaching Certification.

Pennsylvania Head Start Association (Pennsylvania HSA)

5. Pennsylvania HSA is a statewide, non-profit, non-partisan organization dedicated to improving the future for children, families, and communities who are economically challenged. As a responsive and collaborative organization, it

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embraces diversity, promotes comprehensive services, and unifies the early childhood community in Pennsylvania by offering professional development and training for its member Head Start agencies, providing networking and information-sharing opportunities, and advocating at the federal, state, and local levels on behalf of its members.

6. Pennsylvania HSA is dedicated to:
    a. Advocating for children and families to ensure every child reaches their full potential.
    b. Promoting diversity, inclusion, and equity in all aspects of its work, creating a supportive and accessible environment for all stakeholders.
    c. Unifying the early childhood community through collaborative efforts, professional development, and information sharing.
    d. Leading efforts to provide comprehensive services that address the needs of vulnerable children and families across Pennsylvania, including immigrant children and families.
    e. Acting as a voice for the economically challenged, fostering policies and practices that promote social and economic fairness.
7. Pennsylvania HSA's 60 member agencies serve over 32,300 children and 30,000 families.
8. Nine members are government agencies.
9. The remaining 51 members are nonprofit agencies.
10. Pennsylvania HSA has one member that runs two Migrant and Seasonal Head Start programs. In 2024, there were 264 children enrolled in those programs.
11. Pennsylvania HSA members provide critical services to some of the most vulnerable and underserved people in Pennsylvania, including children who are diagnosed with disabilities, children who are in the foster care system, families that are under family court supervision, families experiencing homelessness, and

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immigrants. Most of the families served by members are well below the federal poverty level. About 65% of the children and families served by members are people of color. Around 25% of children served by Pennsylvania HSA members speak a language other than English. Pennsylvania HSA members also serve a significant number of children and families in the many rural parts of the state, where access to quality childcare facilities is particularly scarce.

12. Pennsylvania HSA members utilize a two-generational approach to provide comprehensive services focused on setting up children and their families for success in and out of the classroom. These services include:
    a. Emergency and crisis intervention that provides immediate needs for food, clothing, or shelter.
    b. Housing assistance, such as subsidies for utilities and home repairs.
    c. Asset building services, such as financial education and debt counseling.
    d. Mental health services, including counseling and therapy.
    e. Substance misuse prevention and treatment, including substance misuse therapy, counseling, and education.
    f. Assistance in enrolling into education and job training programs.
    g. Education on preventative medical and oral health and nutrition.
    h. Comprehensive child care, allowing parents to go to work.
13. Pennsylvania HSA was founded in 1993.
14. Pennsylvania HSA has two staff members, including myself.
15. Pennsylvania HSA is funded by membership dues and grants.
16. Pennsylvania HSA member agencies receive Head Start grants, and the members use those grants to fund their Head Start programs that provide services to children and families who are eligible under the Head Start Act, as well for continuing education, training and professional development like that provided by

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Pennsylvania HSA. Grant funds are not given directly to any child or family.

17. Pennsylvania HSA members have discretion as to which eligible children and families are accepted into their programs. Specific children or families are not entitled to enrollment into Head Start programs or services provided through Head Start grants.

Head Start Eligibility Has Never Depended on Immigration Status

18. It is my understanding that the Department of Health and Human Services (HHS) issued a Notice of Interpretation that reinterprets the meaning of "federal public benefit" under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). It is my understanding that this Directive seeks to make Head Start a federal public benefit, thus requiring Head Start agencies—including Pennsylvania HSA members—to verify that children and families enrolled in Head Start are "qualified aliens."

19. This is a radical departure from what I understand to be the eligibility requirements of the Head Start Act. Head Start program eligibility has never depended on immigration status.

The HSS Immigration Directive is Vague and Ambiguous

20. Important aspects of the HHS policy are confusing to Pennsylvania HSA and its members. Pennsylvania HSA and its members do not know if nonprofit organizations are subject to the Directive, and if so, how to account for PRWORA's nonprofit exemption from the verification requirement.

21. It is also unclear as to whether Pennsylvania HSA members will need to verify the immigration status of children who are already enrolled in their programs, and if so, when, and at what intervals.

22. It is also unclear whether Pennsylvania HSA members are now mandated to inquire into the immigration status of parents, only their children, or both.

23. Members face potential False Claims Act liability if the administration believes

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they have not followed the Directive, even despite their best efforts to do so. In addition to the potential civil and criminal legal penalties, failure to comply with the Directive could also result in shutting down Head Start programs altogether.

HHS' New Directive Will Severely Harm Pennsylvania HSA Members, Children, Families, and Communities

24. If Pennsylvania HSA members are required to screen for and verify immigration status, members and I expect the following harms to ensue.

Significant Decreases in Attendance and Enrollment

25. Members will experience significant decreases in attendance and enrollment of children and families in their programs.

26. Children and families who are deemed to be "unqualified" will be disenrolled from programs they are already in, and they will either not apply to or will be rejected from Head Start programs.

27. Such decreases in enrollment and retention will have far-reaching negative consequences.

28. First, children and families will be deprived of the Head Start programming and resources that they rely on for early childhood development and school readiness, including, but not limited to: early education, meals, health screenings, medical services, counseling and therapeutic services, childcare, financial readiness resources, homelessness relief, domestic violence refuge, and training and professional development for seeking employment. These children will fall behind in their development.

29. This will lead to communities at large being destabilized as the children fall behind in their development and the harm will be compounded over time. Families that are already dealing with poverty will be further destabilized without Head Start, and will have even less of the support needed for their family to be successful.

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30. Without Head Start programs providing childcare, immigrant parents and families will lose their ability to work and go to school to support their children.

31. Second, significant decreases in enrollment will cause members to become underenrolled. This exposes them to the penalties for under enrollment laid out in the Head Start Act, which include increased monitoring, funding reduction, and, ultimately, grant termination. If members lose their grants, they will be forced to close their programs altogether.

32. HHS is currently increasing enforcement of its Full Enrollment Initiative. Due to that Initiative, some Pennsylvania HSA members are under monitoring periods that far surpass previous enforcement of under enrollment rules. Despite members overhauling their recruitment efforts to meet enrollment targets in recent years, their progress will be undermined by the new HHS Directive. Members that are already under the Full Enrollment Initiative will only be at greater risk of having funding clawed back or losing their grants when they experience the decline in enrollment due to HHS' new immigration status Directive. I fear that more members will be subjected to this Initiative because they experience underenrollment due to having to exclude children and families from their programs.

Chilling Effect on Attendance and Enrollment

33. Requiring Head Start agencies to inquire about and verify immigration status will have a chilling effect on attendance and enrollment for Pennsylvania HSA members that will not be limited to just "unqualified" immigrants.

34. My members and I expect that children and families who would be deemed "qualified" for Head Start will be scared from attending or enrolling in Head Start programs. Some families will be fearful that participating in Head Start could affect their immigration status or future applications for change in status. Some families will be confused about whether or not they are "qualified" and will stay

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away from Head Start out of caution. Some families will no longer see Head Start as a welcoming and safe program if they will be questioned about their immigration status by Head Start staff, and will choose not to participate. I expect that many families from the large refugee community in Pennsylvania will no longer participate in Head Start, even if they are deemed "qualified."

35. Having member agency staff question children and families about their immigration status will break the trust members have built with families and communities for decades. This trust is a critical part of recruiting and serving children and families in accordance with the Head Start Act.

36. My members and I believe that even children and families who are not immigrants, but are otherwise vulnerable, will no longer feel welcome or safe at Head Start once they know that Head Start staff are now being required to verify immigration status. Members' staff will be seen less like caregivers and teachers and more like law enforcement.

A Verification Requirement Will Disrupt Members' Operations as Well as Pennsylvania HSA's

37. Putting this verification requirement on members' staff will also have collateral damage to the program staff themselves. I have personal knowledge that members are having staff retention issues, as many of their staff are already struggling with high levels of stress and anxiety due to the actions the administration has already taken against Head Start. Requiring staff to inquire about and verify immigration status puts them in the position of having to act more like a law enforcement officer and will increase their stress and feelings of vulnerability. It is incredibly invasive to demand information about immigration status, especially when your role as staff in a Head Start program is to make the program a welcoming, compassionate, and caring place for children and families. Staff and potential job applicants alike will not want to verify immigration status. This will exacerbate

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the staffing issues members are already facing.

38. In addition to staffing issues, the verification requirement will put heavy financial costs on members that will impact their operations. Members do not currently screen for immigration status. They have no procedures, data management systems, or training to conduct verification. It will be costly for them to create or develop the means to meet any verification requirement.

39. Allocating resources towards this verification requirement ultimately takes them away from the work for children and families that members are required to do under the Head Start Act.

40. Members will also need to make significant and costly changes to their recruiting and outreach programs in order to attempt to meet enrollment requirements under this new immigrant exclusion Directive.

41. Funding decreases or claw backs resulting from under enrollment due to the Directive will require members to lay off staff. This will impair the quality of the services they provide to children, families, and their greater communities.

42. Both Pennsylvania HSA and its members will need to consult with attorneys in order to be advised on how to comply with the new HHS Directive since it seems so easy to run afoul. This is an additional cost that will burden operations.

43. The HHS Directive also appears to conflict with priorities of the Head Start Act, particularly as it relates to the requirement to prioritize limited English proficiency students. Many of these students will likely be implicated by the Directive, will no longer be eligible for Head Start and will need to be excluded from enrollment.

44. Members will end up underserving limited English proficient students those required to be served by the Head Start Act out of fear.

45. All of these negative effects created by the HHS policy are compounded for members that operate in rural parts of Pennsylvania. As discussed in paragraph 55

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of the first declaration I submitted in this case, some members are in such rural areas that even slight changes that affect staffing—let alone a change as substantial as this HHS Directive. The compounding effect is also felt by the children and families served in rural areas. If they cannot participate in Head Start, or choose not to out of fear or feeling unwelcome, they likely do not have other options for getting the critical services Head Start provides.

46. Pennsylvania HSA faces direct harm to its operations as a result of the harms to its member agencies.

47. When member agencies lose funding, it becomes more difficult for them to pay membership dues, and thus the loss of enrollment expected as a result of the HHS policy informs Pennsylvania HSA's risk of losing funding. When members have their grants terminated, Pennsylvania HSA will effectively lose membership.

48. Pennsylvania HSA's only other funding source outside of dues is conferencing fees received from Head Start agencies that send staff to professional development conferences conducted by Pennsylvania HSA. With members expecting loss of enrollment and substantially increased risk of loss of funding, I expect that less people will attend our conferences. For example, we have an upcoming conference in November for members, and I expect a loss of funding through conferencing fees because members cannot afford to send as many staff to the conference.

49. I fear that both Pennsylvania HSA and its members will lose important partnerships and collaborative relationships with community partners. For example, members have working relationships with domestic violence shelters and homeless shelters where member staff visit to recruit families or conduct home visits. Members work with food banks to host Head Start families and run programs for Head Start attendees to receive food and cooking tips. Members work with local libraries to plan and conduct weekly Head Start events. Members

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work with local organizations to provide meals, books, and shelter to members' enrolled families. I fear that these community partners will start to limit their interactions and associations with Head Start agencies and Pennsylvania HSA because of the new requirement that Head Start investigate and verify immigration status. This loss of these relationships and collaborations will be felt heavily by the children and families served by Pennsylvania HSA members.

50. This Directive will impair Pennsylvania HSA's ability to fully engage in its core work of training, professional development, and advocacy that it provides for members. Instead of concentrating on its primary responsibilities, Pennsylvania HSA will have to devote the significant part of its resources towards guiding members in applying the vague and ambiguous Directive and navigating the existential threats to their programs.

51. Pennsylvania HSA's small staff and limited resources will be severely burdened by the need to respond to the new HHS Directive. Members are already raising serious fear and confusion—from both themselves and the families they serve—as they are faced with yet another new restriction on the Head Start program that will greatly impact their livelihoods and families.

52. Enjoining the new HHS Directive will protect the children and families served by members, member agencies themselves, and Pennsylvania HSA from the harms detailed in this declaration.

I declare under penalty of perjury under the laws of the United States and the State of Washington that the foregoing is true and correct.

Executed this 21st day of July 2025.

/s/ Kara McFalls

Kara McFalls

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The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

DECLARATION OF LAURI MORRISON-FRICHTL IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER/TO POSTPONE EFFECTIVE DATE OF AGENCY ACTION

NOTE ON MOTION CALENDAR: JULY 21, 2025

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I, Lauri Morrison-Frichtl, hereby attest as follows:

I. BACKGROUND

1. I am over eighteen years old, of sound mind, and fully competent to make this declaration. I have personal knowledge of the factual assertions set forth below.[1]

2. I have served as the Executive Director of the Illinois Head Start Association (Illinois HSA) since 2006. As Executive Director, I am responsible for directing all operations of the Association, including planning and organization, communication, professional and leadership development, advocacy and partnership building, and financial management of the organization. Prior to joining Illinois HSA, I worked as a Training and Technical Assistance specialist at The Ohio State University and also served as Director of a Head Start program in Illinois. I earned a Bachelor's degree in Speech Pathology from Ball State University in 1986 and a Master's degree in Education from Western Michigan University in 1988.

3. Illinois HSA is a 501(c)(3) non-profit, non-partisan association of federally recognized Illinois Head Start and Early Head Start grantee and delegate agencies in operation since 1978. Illinois HSA acts as the voice of Illinois Head Start and Early Head Start programs, staff, and parents, serving over 28,800 children and their families in all 102 counties in Illinois.

4. Illinois HSA's mission is to provide guidance and support to Illinois Head Start and Early Head Start programs to ensure their ongoing viability and vitality to operate high impact, community driven services for Illinois' most vulnerable children and families. Illinois HSA advocates for its members at the federal, state, and local levels, offers professional development and training resources for Head Start agencies and their staff, and provides opportunities for parents and families to connect, share, and grow. Recently, this has included building awareness and leading advocacy efforts regarding Head Start and Early Head Start programs, leading collaboration and partnerships in the early childhood education space in

[1] I also incorporate into this declaration the information contained in the declaration I submitted in support of Plaintiffs' Motion for a Preliminary Injunction, filed on May 16, 2025. ECF No. 41.

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Illinois, sponsoring professional and leadership development opportunities, and developing supportive resources for our members. Illinois HSA maintains regular contact with its members, including issuing a weekly newsletter; hosting a weekly "huddle" for members to share information, raise questions, and provide feedback; leading monthly meetings with Head Start program directors; and maintaining social media accounts to keep members informed and offer informal networking opportunities.

5. Illinois HSA's funding is comprised of membership dues, fees generated from professional development opportunities offered to members, and contracts and grants from outside entities. Illinois HSA has a staff of two full-time employees (myself and a Director of Learning) and two part-time employees (a Director of Operations and a Director of Member Engagement and Outreach).

6. Illinois HSA is governed by a Board of Directors made up of the Directors of Illinois Head Start agencies and other stakeholders in the early childhood education field, including Head Start staff, parents, and community partners. The Board oversees the staff and functions of the Illinois HSA, including setting the strategic direction and providing oversight for the Association.

7. Over the course of my tenure with the Illinois HSA, the focus and priorities of the Association have changed over time to meet the needs of our members – for example, providing additional supports to members serving immigrant and refugee populations; offering resources for children with disabilities in response to increased diagnoses of autism and developmental disabilities; developing supports for children and families involved with the child welfare system; and adapting to changes during and after the COVID-19 pandemic to support the behavioral and physical needs of children and families. Illinois HSA conducts a comprehensive needs assessment twice each year to ensure that it is offering resources and services targeted at the current needs of its members and the communities they serve.

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II. MEMBERSHIP OF THE ILLINOIS HEAD START ASSOCIATION

8. The membership of Illinois HSA includes 51 federally recognized Head Start agencies and 84 delegate agencies operating 513 program sites statewide. Four of the 51 agencies are operated by city or state government entities; three are housed within public universities; and five are run by local school districts.

9. Illinois HSA members serve over 28,800 low-income children and their families in all 102 counties in Illinois. Of the total Illinois Head Start population, 14.3 percent are children with disabilities; 3.8 percent are children in foster care; and 7.9 percent are children experiencing homelessness. Nearly two-thirds are children of color, with 41 percent identifying as Black and 36 percent identifying as Hispanic. They live in communities ranging from Chicago, the third largest city in the country, to rural farming areas. To meet these widely and richly diverse needs, Illinois HSA members offer an equally wide array of services, including initiatives focusing on school-readiness for Black boys (which has recently been discontinued); English language learning and job placement resources for immigrant parents; on-site health clinics and food pantries; and regular staff training to reduce bias and improve equitable access to all Head Start services.

10. Illinois HSA also has members who operate Migrant and Seasonal Head Start programs, who serve 360 children in Illinois via seven delegate agencies strategically located across the State. These programs adapt their calendar to the summer months to accommodate the unique schedule and needs of agricultural workers in Illinois's seed corn fields, before the children and their families traditionally move on to other locations.

11. In 2024, Illinois HSA members received approximately $479 million in federal Head Start grants. Members use these funds to tailor programs to meet the needs of eligible children and families, as well as for continuing education, training, and professional development like that provided by Illinois HSA. The grant funds are not distributed directly to any individual child or family.

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III. SERVICES PROVIDED BY ILLINOIS HEAD START ASSOCIATION MEMBERS

12. I understand that Head Start agencies must recruit participants from all parts of their communities, including traditionally underserved populations, and they must also include families and community members in the development and implementation of local Head Start programs. This begins with the Community Assessment, described in the Head Start Performance Standards as the "community-wide strategic planning and needs assessment." It is an essential first step in designing a program that meets the needs of local children and families. Data from the Community Assessment is used to develop program-wide goals for the provision of responsive, high-quality services.

13. Members of Illinois HSA serve significant populations of immigrant, refugee, and other limited English proficient families throughout the state; for example, we know based on the information gathered through their community assessments that approximately 33 percent of children are dual language learners. Consistent with the Head Start Performance Standards, to best serve these populations HSA members prioritize dual language services in the classroom; provide written recruitment materials in multiple languages to ensure all eligible families are aware of the services available; offer simultaneous translation services during parent meetings to support engagement; and provide referral resources for immigration matters.

14. Illinois HSA members collaborate closely with families to understand their unique needs, values, and goals. They solicit parent input in program planning, policy-making, and continuous improvement efforts, ensuring that services are aligned with the real needs of the community. They host multicultural events and invite families to share their customs, languages, and experiences with the children and staff, and they provide books, literacy materials, and family communications in multiple languages reflective of enrolled families, including simultaneous translation services at parent meetings to help break down barriers to full family engagement for limited English speakers.

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IV. IMMIGRATION STATUS HAS NEVER BEEN INCLUDED IN HEAD START ELIGIBILITY CRITERIA

15. I understand that since the Head Start Act was originally enacted, immigration status has never been included among the eligibility criteria, and Illinois HSA members do not screen applicants for eligibility based on immigration status. Illinois HSA members have come to rely on this practice, and requiring them to do so now would be incredibly burdensome, and would likely discourage enrollment for the reasons discussed here.

16. Our members do not have infrastructure in place to verify immigration status for individual applicants and families. Head Start agencies already collect a substantial amount of personal information regarding the children and families participating in their programs including, for example: dates of birth, race and ethnicity, primary and secondary language, parent and guardian employment and education information, 12 months of income documentation, housing status, household member information, SNAP/TANF/SSI status, health and medical history, and more.

17. For families experiencing homelessness, however, the McKinney-Vento Act instructs states and school districts to remove barriers to identifying and enrolling eligible children, which means that when these families are unable to provide the typical documentation, they are not required to do so.

18. Requiring Head Start agencies to verify immigration status, on top of the already burdensome application process, would require significant financial, personnel, and time from Illinois HSA members. For example, several members anticipate they would need to hire or reassign additional administrative staff to manage the increased workload in order to meet application and enrollment deadlines for the 2025-2026 school year. Staff will also require training about the types and definitions of various immigration statuses, which statuses qualify for eligibility, and the types of documentation sufficient to prove statuses. Agencies may also need additional recordkeeping or IT resources to verify the validity of the documentation submitted and store this sensitive information securely. Moreover, because

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families themselves may not know how to accurately articulate their immigration status, this would compound the burden on our members.

IV. THE IMMIGRANT EXCLUSION DIRECTIVE IS VAGUE AND AMBIGUOUS, AND ILLINOIS HSA MEMBERS ARE UNCERTAIN HOW TO COMPLY

19. I am aware that on July 14, 2025, the Department of Health and Human Services published a Notice of Interpretation (the "Immigrant Exclusion Directive") of the term "federal public benefit" as used in the Personal Responsibility and Work Opportunity Reconciliation Act ("PWRORA"). The Immigrant Exclusion Directive provides no guidance to Illinois HSA members on how to comply with its terms under existing law.

20. For example, I understand that under PRWORA, "nonprofit charitable organizations" are exempt from any requirement to verify the immigration status of applicants. But the Immigrant Exclusion Directive highlights that nothing in the statute prohibits nonprofits from conducting verification, and it warns that "all entities . . . should pay heed to the clear expression of national policy described above." Faced with this thinly veiled threat, Illinois HSA nonprofits are caught between relying on the statutory exemption or facing the uncertainty of potential False Claims Act liability or other penalties if they do not voluntarily comply with this "policy."

21. The Immigrant Exclusion Directive does not specify whether eligibility will be determined based on the immigration status of the child, the parent or other family member, or both. For example, based on my general understanding of the composition of the immigrant population in the state, Illinois HSA members are likely serving many U.S. citizen children whose parents are undocumented or present in the United States with temporary protected status or student or other temporary visas. And programs traditionally collect information related to the parents or household – e.g., income verification – to determine the eligibility of the child. Further, Early Head Start programs also provide services to pregnant women. Are those programs expected to consider the immigration status of the pregnant mother or the

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unborn child? The policy does not address this key issue of whose immigration status must be determined to qualify for enrollment.

22. The Immigrant Exclusion Directive also does not specify whether programs are expected to verify the immigration status of children who are already enrolled – and if so, when and how often. Under the Head Start Act, once a currently enrolled child has been determined to meet the eligibility criteria, that child is considered to meet the criteria through the end of the succeeding program year. The Immigrant Exclusion Directive states that it is effective immediately, but it does not indicate whether programs are expected to re-evaluate already enrolled children to screen for immigration status immediately, or on some other timeframe.

V. HARM TO ILLINOIS HSA MEMBERS FROM IMMIGRANT EXCLUSION DIRECTIVE

23. Since this Administration issued its Executive Orders directing agencies, including HHS, to stop providing services to "illegal aliens," Illinois HSA members have seen declines in attendance and enrollment among immigrant families – regardless of their legal status – due to concerns of immigration consequences. They anticipate that the Immigrant Exclusion Directive will exacerbate this trend, particularly now as Illinois HSA members are currently "knee deep" with enrolling children and getting ready to start a new school year. Most of the programs have completed their recruitment efforts and are now working with families to get the child's developmental screening completed, along with all the health screenings (lead, TB, immunizations, etc.)

24. I understand that the Head Start Act instructs agencies to prioritize enrollment of limited English proficient students, many of whom may no longer be eligible under the new policy. Further, requiring Head Start agencies to identify and "weed out" applicants based on immigration status would create a chilling effect on participants who remain eligible. This policy would likely discourage enrollment of otherwise eligible children due to the fear that participation could negatively impact their parents' immigration status—for example, by deeming them a "public charge" and limiting their ability to adjust their immigration status.

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25. Maintaining eligibility for Head Start services regardless of immigration status allows families to participate without fear of these repercussions, and it allows agency staff to maintain trust with the local community—an important consideration for recruitment, retention, and overall quality of the services provided.

26. Though Illinois HSA members do not maintain routine records on immigration status, based on their familiarity with the children, families, and communities served, some members anticipate their enrollment could decline by 20% or more – including both children who are no longer eligible and otherwise eligible families who are deterred from participating due to this new policy.

27. For example, one Illinois HSA member operates a program in a lower income neighborhood that is 80% Latino. Though this member does not collect information on immigration status, they are aware that undocumented residents make up a significant portion of the local community, and by extension they likely comprise a good number of the families they serve. In recent months, even before the Immigrant Exclusion Directive was published, families have raised concerns about immigration-related consequences of remaining in the program, and this member has seen significant attendance issues since January of this year. Similarly, two other Illinois HSA members estimate that about 45% of the children they serve belong to immigrant families, at least some significant proportion of whom include family members who are undocumented. Both organizations have noted a consistent decrease in attendance compared with enrollment since January of this year.

28. For one government agency member in a community with a significant refugee population, the chilling effect is particularly noticeable in the Early Head Start home visiting program, in which staff members provide home-based services for children age zero to three and their families. This program typically experiences high turnover, and reluctance by local families to participate will only exacerbate enrollment concerns, because they will feel vulnerable with sharing information about where they live for fear of it being shared with federal immigration enforcement agencies

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29. Another Illinois HSA member serves a significant number of children whose parents attend the local university on student visas. Based on the definition of "qualified alien" under PWRORA, it is this member's understanding that those children and families would no longer be eligible, which will impact their overall enrollment. Whether this member's understanding is correct or not, I cannot say, but it highlights the problem of potentially eligible families not accessing Head Start because of confusion about whether or not they are eligible.

30. Decreased enrollment will in turn impact the ability of Illinois HSA members to comply with the terms of their grants. At the same time, the Office of Head Start has increased enforcement of its full enrollment initiative. In recent weeks, at least two large programs in the Chicago area have received letters notifying them that OHS will be recapturing funding due to under-enrollment. This loss of funding forces programs to lay off staff – including staff with linguistic and cultural competency to serve the diverse needs of their communities – and diminishes the overall quality of services that the program is able to provide for the children who remain enrolled.

31. Moreover, requiring Head Start program staff to inquire into and screen for immigration status diverts from the core operation of their programs. Several Illinois HSA members note concerns from their staff that they will be forced to participate in immigration enforcement efforts that are inconsistent with the mission of their programs – to serve the most vulnerable children and families in their communities. These members also raise concerns that they may lose staff if they are required to comply with this new policy.

VI. HARM TO CHILDREN AND FAMILIES FROM THE IMMIGRANT EXCLUSION DIRECTIVE

32. As discussed above, Illinois HSA members estimate that enrollment may decline by 20% or more due to this new policy. I understand that HHS itself estimates that about 16% of currently enrolled children will be impacted. Relying on the Department's figure, this translates to at least 4,608 children and their families statewide who will lose access to high quality early childhood education services in Illinois.

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33. If children from immigrant families are no longer eligible to participate in Head Start, or are deterred from attending due to fears of immigration or other consequences, they will not only lose access to quality early childhood and educational readiness for primary and secondary education relative to their peers, but they will also lose out on the supplemental services Head Start affords them to support their health and development, including access to routine developmental screenings, physical and mental health services, nutritious meals, and supports for children with disabilities, such as speech, occupational, and physical therapy.

34. Immigrant parents and families will either be unable to work and go to school to support their children, or they may be forced to leave their children in unsafe environments to continue providing for their families. They will also be deprived of the resources Head Start programs offer to parents and caregivers, such as parenting classes, housing assistance, and job placement services.

35. The uncertainty about how this policy will be implemented and enforced puts immigrant families in an impossible position. For example, families participating in a Head Start program run by a nonprofit organization may not be asked about their immigration status, if that program decides to rely on the screening exemption provided by PWRORA. If parents enroll their child, assuming they are eligible, but later learn they don't qualify, they could face immigration consequences or other penalties.

36. Even non-citizen families who remain eligible as "qualified aliens" may be reluctant to enroll their children for fear that participation will be used to declare them a "public charge" and prevent them from applying for permanent residency, citizenship, or otherwise adjusting their status.

VII. HARM TO ASSOCIATION FROM THE IMMIGRANT EXCLUSION DIRECTIVE

37. The new policy will also directly harm the Illinois HSA, including by impairing its ability to fully engage in its core work of training, technical assistance and advocacy that it carries out for its members.

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38. Illinois HSA's small staff and limited resources will be burdened by the need to respond to the Immigrant Exclusion Directive, including to address the justified fear and understandable confusion from members and the families they serve, given the significant impact on their lives.

39. Illinois HSA will have to divert staff time and resources away from its core activities to educating its members on how to navigate compliance with the new policy, including counseling the communities on how to avoid running afoul of the new policy.

40. This will mean Illinois HSA staff have less time and fewer resources to work on other critical issues, such as state-level policy and systems work related to Illinois's current efforts to consolidate all early childhood services under a new Department of Early Childhood.

41. The Immigrant Exclusion Directive will also likely cause Illinois HSA to lose members, because the decline in enrollment may mean their grants will be terminated or because they cannot otherwise afford or justify the expense of Illinois HSA's membership dues.

42. This could force Illinois HSA to reduce staff, or shutter altogether, as the majority of the Association's funding comes from dues paid by its members.

VIII. BENEFIT OF ENJOING THE IMMIGRANT EXCLUSION DIRECTIVE

43. Enjoining the Immigrant Exclusion Directive would protect Illinois HSA and its members from distractions and diversion of resources necessary to address the harms, panic, and misinformation it will cause if it goes into effect.

44. A Temporary Restraining Order would allow Illinois HSA and its members to focus on critical longer-term projects to ensure members meet the obligations of the Head Start Act, including providing essential quality early childhood education for the State's most disadvantaged children.

45. A Temporary Restraining Order would protect children and families from unintended consequences caused by the new policy, in particular the ambiguities that remain about which children remain eligible for Head Start services and how programs are expected

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to comply with these new requirements – ambiguities that could result not only in eligible children being denied services, but in negative immigration consequences to those children and their families.

46. A Temporary Restraining Order will also help to prevent the chilling effect of this new policy which, if it is allowed to go into effect, will prompt otherwise eligible families to withdraw their children due to fear about the consequences of continuing to participate.

Pursuant to 28 U.S.C. § 1786, I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 21, 2025

Lauri Morrison-Frichtl

Lauri Morrison-Frichtl

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The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

DECLARATION OF JOEL RYAN IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER/TO POSTPONE EFFECTIVE DATE OF AGENCY ACTION

NOTE ON MOTION CALENDAR: JULY 21, 2025

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I, Joel Ryan, hereby declare and state:

1. The information in this declaration is true and correct to the best of my knowledge and I am of majority age and competent to testify about the matters set forth herein.

2. I incorporate all of the facts and allegations contained in my first declaration submitted in this case in support of Plaintiffs' Motion for a Preliminary Injunction.

Experience and Professional Background

3. I am the Executive Director of the Washington State Association of Head Start and Early Childhood Education and Assistance Program ("Washington HSA"). I have served in this role since 2007.

4. In my current role at Washington HSA, I oversee all operations of the organization, including WSA's funding and policy advocacy at the state and federal level and providing professional development for Head Start program members. This includes offering training for Head Start staff and program members on ways to tailor their curriculum to best serve their diverse children and families, and support member programs in making their programs more inclusive for children to best meet their obligations under the Head Start Act and related state laws.

5. Most of my education and experience prior to being at Washington HSA has been focused on early childhood education and the Head Start program. While earning my bachelor's degree, I wrote my senior thesis on Head Start programming. After college, I served as an AmeriCorps volunteer providing literacy support for children at a Head Start school in Boston, MA. Thereafter, I received my law degree from American University, where I served as intern for Neighborhood Legal Services, the Coalition for the Homeless, and several child advocacy organizations.

6. After receiving my law degree, I served as the Government Affairs Director of the National Head Start Association. In that role, I worked as the liaison between the Head Start community, Congress, and the White House. I have more than 20+ years of experience supporting Head Start programs, children, and families.

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The Guiding Principles of the Head Start Program

7. As discussed, I have been steeped in the intricacies of the Head Start program for the better part of my academic and professional life. For 60 years, the purpose and mission of Head Start has been to make sure that all children are ready for success in school regardless of their background, race, zip code, or income.

8. The Head Start Act requires funding to be directed to approved agencies that focus on serving children and families that are the furthest away from opportunity. To identify those populations most in need of services, Head Start agencies are required under the Head Start Act to conduct community wide assessments that collect and analyze demographic data.

9. Head Start agencies are multigenerational programs that provide services to children as well as their families. This is because parents are a child's first teacher and early child teachers and caregivers must work with parents as co-equals in their child's education. Head Start agencies provide services starting from the time when a mother is pregnant, and throughout a child's preschool age from 0-5 years old. Head Start agencies provide case management services for families to help them set up their children for success. Head Start services in this area include helping families find housing, helping parents set and meet goals to go to school or work, providing financial literacy education, and working with parents on nutrition and behavioral health so they can help their kids at home.

10. Not all children are at the same starting point when they arrive at school. That is why Head Start agencies need to offer different services and resources based on need. Head Start is, at its heart, an equity program, which I understand to mean affording all children a fair chance to be ready for kindergarten and succeed by providing them resources tailored to their diverse circumstances.

11. As required by the Head Start Act, Head Start serves children and families in need who are the furthest from opportunity. That is why Head Start services are focused on some of the children from the country's most vulnerable communities, including immigrants. This means children who are very low income and children and families of color, including a

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significant number of immigrant families. The majority of children who are served by Head Start are low-income children of color. Up to two-thirds of all Head Start program attendees are Black or brown children. Head Start serves a high number of English language learners. Immigrants and refugees make up a large share of the population served by Head Start. Around 18% of the children served by Head Start are diagnosed with disabilities.

12. Head Start teaching staff must have the background and knowledge to support the needs of the children and families they serve. Given the diversity of the populations they serve, this means that they must have relevant linguistic and cultural competency.

13. To effectively provide services, Head Start agencies must consider the cultural norms of children and their families so that the agency can help the parents support their child's learning and development at home. Appropriate engagement with a Head Start family requires Head Start agencies to use culturally appropriate engagement. Head Start programs thus need their curriculum to be relevant to the populations they serve. As an example, it is critical for parents that are non-English speakers to understand what their children learned during their day at Head Start. Head Start teachers will often send materials, books, and other activities for parents to work on with their child at home. It is critical that these be understandable to the family and, if necessary, translated so that parents can fully support their child's education. Ultimately, Head Start agencies want to create a welcoming environment for children and families in order to carry out their obligations under the Head Start Act.

Washington HSA's Mission, Purpose and Alignment with the Head Start Program

14. Washington HSA is a statewide non-profit membership association founded in 1986 and is currently composed of 30 member agencies from early childhood care and education agencies that are funded by Head Start, Early Head Start, Migrant/Seasonal Head Start, Native American Head Start, and the Washington state Early Childhood Education and Assistance Program ("ECEAP").

15. Twelve member agencies are nonprofit charitable organizations, which account for 44.2% of Head Start program slots in our membership. Five grantees are nonprofit

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community action agencies, which account for 11% of Head Start program slots.

16. Fourteen member agencies are local government-run programs, including schools, educational services districts, community colleges, and municipalities, which account for 44.8% of Head Start program slots.

17. Washington HSA's mission is aligned with Head Start's mission: serving the children and families farthest from opportunity.

18. Washington HSA's purpose is to strengthen Head Start, Early Head Start, and ECEAP agencies for the benefit of children and families, through advocacy, education, and collaboration. Washington HSA strives to work in collaboration with children, families, and communities to advocate for antiracist and equitable early learning, education, and human services systems that provide opportunities for all children and families. Washington HSA is committed to supporting children and families of all races, genders, languages, abilities, sexual orientations, nationalities, immigration status, and socioeconomic status.

19. As of 2025, Washington HSA members serve over 13,000 children and their families.

20. Washington HSA members provide critical services to people from some of Washington's most vulnerable and underserved communities.

a. Over 74% of the children served by Washington HSA members are children of color.

b. Nearly 42% of the children served by Washington HSA members speak a primary language other than English at home with their family. Over half of the children served by Washington HSA members are dual language learners. For example, with a large population of low-income Mandarin-speaking immigrants from China in Seattle, WA, Head Start agencies tailor their programs and services to Mandarin Chinese-speaking students and families. It is common for this Head Start program to celebrate the Lunar New Year. In Yakima, WA, Washington

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HSA members serve migrant farm worker families and provide them culturally relevant curriculum and offerings in a family's home language of Spanish. And, in Skagit County, WA, Head Start agencies serve a larger number of Ukrainian refugees among others. These families are dealing with the trauma of coming from a war-torn country and the associated complex issues that can develop as a result.

c. In 2024, there are 1,956 children and four pregnant women enrolled in members' Migrant and Seasonal Head Start programs.

d. Around 14% of all children served by Washington HSA members are diagnosed with a disability and have an Individualized Education Plan.

e. Almost 15% of the children served by Washington HSA members are involved in early family intervention services.

f. Over 25% of families served by Washington HSA members have parents with less than a high school education. Nearly 13% of Washington HSA families served have one or more parents in a job training program.

g. Most families served by Washington HSA members are well below the federal poverty level, and over 12% of families served by Washington HSA members experience homelessness every year.

21. Like other Head Start agencies, Washington HSA members receive Head Start grants from the federal government. Members use those grants to fund their Head Start programs that provide services that are tailored to the needs of eligible children and families, as well as for continuing education, training and professional development like that provided by Washington HSA. Grant funds do not go directly to any child or family.

22. Washington HSA members have discretion as to who enrolls in their programs. Even if they meet the eligibility criteria stated in the Head Start Act, specific children or

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families are not entitled to enrollment in Head Start programs or services provided through Head Start grants.

23. Washington HSA operates with a budget of $1.2 million. Washington HSA is funded by membership dues, grants, and training and conference registration fees. Washington HSA has three full-time staff members.

Immigration Status Has Never Been Part of Head Start Eligibility Criteria and Requiring Agencies to Verify Status Will Subject Members to Significant Harms

24. I am aware that the Department of Health and Human Services (HHS) has submitted a new Directive that reinterprets the meaning of "federal public benefit" under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). My understanding is that this Directive interprets the services provided by the Head Start program to be a federal public benefit and thus requires Head Start agencies, including Washington HSA members, to verify that children and families enrolled in Head Start are eligible "qualified aliens."

25. Since the formation of Head Start, program eligibility has never depended on immigration status.

26. Making enrollment dependent on immigration status will have a massive chilling effect on children and families enrolling in Head Start.

27. If Washington HSA members are required to verify immigration status and exclude certain classes of immigrants from their programs, they expect to experience significant decreases in enrollment and retention. While Washington HSA members did not record the legal immigration status of the children and families in their programs before the new HHS Directive was put forth, they expect that significant numbers of enrolled children and families will no longer be considered eligible for Head Start and be forced to disenroll.

28. Given the demographic background of the children and families served by Washington HSA's members, I anticipate that enrollment could decline by 15 to 25% as a conservative estimate.

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29. The chilling effect will extend beyond immigrant families. Because Head Start eligibility has always been irrespective of immigration status, Washington HSA members have been able to maintain trust with immigrant communities and other communities of vulnerable people, allowing them to build successful Head Start programs. Requiring members to verify immigration status means that Head Start teachers and staff will need to question applicants and/or enrolled children and families about their immigration status. This invasive questioning carries a heightened level of fear at this time due to the federal administration's actions against immigrants. It will sever the trust that member agencies have built, not just with immigrant communities, but with the community at large as Head Start agencies will now be seen as unwelcoming and potentially dangerous.

30. Washington HSA members serve communities for which fear and distrust of government systems are significant concerns. Families—particularly those who are immigrants, refugees, or limited English speakers—often feel unsafe due to increased scrutiny, racial profiling, or language-based discrimination. A critical part of the success Washington HSA members have with their Head Start programs is the trust they have been able to form with immigrants.

31. Even if the intent of this new HHS Directive is to exclude certain classes of immigrants and not others, it will likely discourage enrollment of otherwise eligible children based on the fear that seeking or receiving Head Start services would affect parental immigration status, such as resulting in the child being deemed a "public charge" and affecting the ability of the parents to adjust their immigration status. Washington HSA members are of the understanding that parents who are not citizens will be too scared to apply their children to Head Start programs, even if it is true that their citizen child is eligible for Head Start.

32. Even when families could have the legal right to access services, the perception of risk may lead them to withdraw from the Head Start program or avoid enrollment altogether. This Directive will create barriers for children who would benefit most from early learning services, further widening the opportunity gaps in already underserved communities.

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33. The chilling effect negatively impacting Washington HSA members will not be limited to just Head Start enrollment. I expect that HHS' Directive will negatively impact members' program enrollment in state funded early childhood education programs—many of which also receive Head Start funding—as families feel unwelcome and/or unsafe in the program generally because the program is screening for immigration status.

34. The chilling effect of HHS' Directive targeting immigrants is especially harmful at this time because Washington HSA members are currently engaged in the enrollment process for filling their programs that start in the fall.

35. Even before HHS' Directive, Washington HSA member agencies were already experiencing negative impacts to enrollment and retention due to the Executive Orders targeting "DEIA" and "illegal aliens" and HHS' policies to execute those Orders.

36. Multiple Washington HSA members have experienced decreases in attendance from immigrant children and families since the Executive Orders and HHS policies. Multiple members also report that immigrant parents have expressed fear of going to work and taking their children to the Head Start program because of the Executive Orders and HHS policies.

37. Consequently, this massive chilling effect due to HHS' immigration Directive will have a deleterious impact on Washington HSA members' ability to meet enrollment requirements under the Head Start Act. The resulting decline in enrollment and retention due to HHS' Directive will make it more likely that member agencies will be underenrolled and thus exposed to the penalties for under enrollment in the Head Start Act.

38. If members are unable to fully enroll their programs, they are at serious risk of having to close their classrooms and facilities, which would deprive all of the children and families in their care of the critical resources received through their Head Start program.

39. In recent weeks, the Office of Head Start has increased enforcement of its Full Enrollment Initiative, making HHS' immigration Directive even more dangerous for members. Some Washington HSA members are already working through the Full Enrollment Initiative and this new Directive will serve to increase the risk that they will lose funding.

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40. Washington HSA members will have to drastically change their outreach and recruiting programs at great effort and cost.

41. The resulting drop in attendance and enrollment will have severe financial consequences for members. Loss of enrollment leads to a decrease in program size, which leads to a loss of Head Start grant money. Members will also lose funding from state funding streams with this drop in enrollment and retention. This bears additional costs to the many members that "braid" their funding sources as discussed in paragraph 87 of my first declaration filed in this case. These members would likely need to shut down their entire program, even if they receive funding outside of Head Start, because of their fund braiding.

42. These funding decreases will require members to lay off staff, and they may no longer be able to afford appropriate training and technical assistance from their remaining staff, including from sources like Washington HSA. Both of these will diminish the overall quality of the early educational services they provide.

43. Members will likely be placed in the Designation Renewal System as a result of the HHS Directive, which threatens their ability to receive Head Start grants.

44. Finally, members will be at risk of having their Head Start grants terminated and closing their program, leading to loss of employment for staff and loss of critical early education resources that will be catastrophic for entire communities.

45. This new Directive also puts members in the untenable position of deciding between violating the new Directive and violating parts of the Head Start Act. For example, the Head Start Act requires agencies to prioritize Limited English Proficiency students, many of whom will likely no longer be eligible for Head Start under the new HHS immigration guidance and thus will need to be excluded from enrollment by Washington HSA members.

46. Verifying immigration status would also likely result in these members running afoul of state law. Washington state law requires public schools, including Head Start agencies, to adopt local policies in alignment with model policies from the Washington Attorney General's Office to ensure public schools remain safe and accessible to all Washington

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residents, regardless of immigration or citizenship status. See RCW 43.10.310. The model policies prohibit public school staff from "inquir[ing] about, request[ing], or collect[ing] any information about the immigration or citizenship status or place of birth of any person." *See* Washington State Office of the Attorney General Bob Ferguson, *Keep Washington Working Act Guidance, Model Policies, and Best Practices for Public Schools*, at 8 (May 2020), https://agportal-s3bucket.s3.amazonaws.com/uploadedfiles/Home/Office_Initiatives/KWW/KWW%20Schools%20Model%20Guidance.pdf. Public school staff are also prohibited from seeking or requiring information regarding the parent or guardian's citizenship or immigration status. *See id.* Even if member agencies that are public schools are required to collect information related to national origin to satisfy federal reporting requirements, they are required under these policies to take measures toward protecting the child and family, including "collecting this information separately from the school enrollment process" to "mitigate deterring school enrollment of immigrants or their children." *Id.*

47. Verifying immigration status and excluding immigrants from programming will also put members at risk of violating the state licensing requirements for early education as discussed in paragraph 84 of my first declaration filed in this case.

48. If Washington HSA members are required to verify immigration status, they do not have the infrastructure necessary to verify immigration status. Members will need to create and develop a recordkeeping system and protocol for gathering and holding this data. They will need to train staff in this new system and potentially hire new staff. A member agency for which 50% of its students have a home language other than English—and thus expects that a large share of its students are immigrants or are from immigrant families—reports that this requirement will be very costly because: (1) it has no process in place to support the collection of immigration status data, (2) its online systems do not support housing this data, (3) its current applications do not have space for this level of detail, and (4) it will need to complete an impact analysis to determine what process it will need to create, budget, and fund.

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49. Screening for immigration status will divert resources from the core operation of programs. These members will bear the cost of this requirement, which will only be exacerbated by the funding and staffing issues they are already facing because of the actions of this administration seeking to dismantle Head Start.

50. Members face potential False Claims Act liability in connection with any reporting obligations they have regarding compliance with the Directive. In addition to the potential civil and criminal legal penalties, this liability also poses an existential threat to members' programs.

The HSS Immigration Directive is Vague and Ambiguous

51. From the text of the HSS Directive, Washington HSA and its members do not know if nonprofit organizations are subject to it, and if so, how to account for PRWORA's nonprofit exemption from the verification requirement.

52. It is also unclear as to whether Washington HSA members will need to verify the immigration status of children who are already enrolled in their programs, and if so, when, and at what intervals.

53. It is also unclear whether Washington HSA members are now mandated to inquire into the immigration status of parents, only their children, or both.

The HSS Immigration Directive Will Severely Harm Immigrant Children and Families

54. Because of HSS' immigration Directive, immigrant children will lose access to quality early childhood care and educational readiness for primary and secondary education. They will fall behind in school readiness relative to their peers and be deprived of the supplemental services Head Start affords their families to support the health, welfare and development of their children, including access to health and developmental screenings, physical and mental health services, nutritious meals, home visits and support for infant and toddler health and development, and supports for children with disabilities, such as speech, occupational, and physical therapy.

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55. Immigrant parents and families also will lose their ability to work and go to school to support their children without having reliable childcare through Head Start. It is my understanding that local farmers are already concerned that they will not have enough workers for the rest of this fruit-picking season because immigrant workers will not be able to take their children to Head Start programs. This will result in significant financial hardship for families that are already dealing with poverty. They will also be deprived of other resources Head Start offers to strengthen their families, including access to parenting classes and other resources to better their psychological well-being and foster economic self-sufficiency.

56. Washington HSA and its members expect that this Directive will have severe impacts on community well-being and stability, as children fall behind in their development and their opportunities for future success become more limited without the resources of Head Start. Entire classrooms could close due to the impacts of this Directive, impacting both immigrant and nonimmigrant children alike, as well as the entire community.

The HHS Immigration Directive Will Harm Washington HSA

57. This Directive will also directly harm Washington HSA by diminishing its ability to fully engage in its core work of training, professional development, and advocacy that it provides for members. Instead of concentrating on its primary responsibilities, Washington HSA will have to devote the significant part of its resources towards guiding members in applying the vague and ambiguous Directive and navigating the existential threats to their programs.

58. Washington HSA's small staff and limited resources will be severely burdened by the need to respond to the new HHS Directive. Members are already raising considerable fear and confusion, from both themselves and the families they serve, as they are faced with this new Directive that poses a significant impact on their lives.

59. The HHS Directive is also likely to cause Washington HSA to lose members, as member agencies experience declines in enrollment that result in grant termination, or

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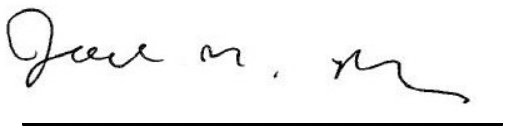
funding decreases that make Washington HSA membership financially unfeasible. This could force Washington HSA to lose staff, consolidate operations, or shut down completely.

60. Enjoining the new HHS Directive would protect Washington HSA, its members, and most importantly, the vulnerable children and families served by members, from the harms described above.

Executed this 21st day of July 2025.

I declare under penalty of perjury under the laws of the United States and the State of Washington that the foregoing is true and correct to the best of my knowledge.

By:



Joel Ryan

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The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

DECLARATION OF CANDICE WILLIAMS (FORMERLY VICKERS) IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER/TO POSTPONE EFFECTIVE DATE OF AGENCY ACTION

NOTE ON MOTION CALENDAR: July 21, 2025

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I, Candice Williams, hereby declare and state as follows:

1. I am over eighteen years old, and I have personal knowledge of the facts set forth in this Declaration. I could and would testify competently to those facts if called as a witness in this case.[1]

I. Family Forward Oregon's Mission, Activities, and Membership

2. My name is Candice Williams (formerly Vickers), and I am the Executive Director of Family Forward Oregon ("FFO"). I have served as the Executive Director since 2023. Prior to serving as FFO's Executive Director, I advocated for and served children and families who have been historically marginalized and systemically denied opportunities to thrive in the education system for over 15 years.

3. In addition to my professional background working as an educator, I am a Black mother of two children and have personal knowledge of and experience with early education and supports for young children.

4. FFO is a statewide non-profit, non-partisan, community-based organization led by and comprised of Oregon mothers and caregivers fighting for gender, economic, and racial justice, and for access to high-quality, affordable, and culturally relevant early childhood education and childcare. FFO's membership is comprised of Oregon mothers and caregivers across intersecting identities of race, class, sexuality, gender identity, immigration status, language, and disability, including parents and family members of children currently enrolled in Head Start programs. FFO's membership also includes Oregon early childhood educators and childcare providers, including current Head Start teachers and staff members.

5. The mission of FFO is to work collectively with Oregon mothers, caregivers, and educators to organize, educate, and advocate for care systems that ensure that families

[1] I hereby incorporate by reference my Declaration in Support of Plaintiffs' Motion for Preliminary Injunction, filed on May 16, 2025.

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obtain economic stability and power, that children and families have access to early childhood education and learning, and where the labor of caregiving is seen and valued. To achieve these goals, FFO builds on the collective power of Oregon mothers, caregivers, and educators through community organizing, leadership development, civic engagement, education, and advocacy. FFO offers many opportunities for training, development, and participation to its members, including, but not limited to, monthly action team meetings; direct actions, including an annual Day Without Child Care to draw attention to the childcare crisis; care summits aimed at engaging and mobilizing members around early education, childcare and other issues; and a statewide parent cohort, comprised of parent members from communities most impacted by the childcare crisis in Oregon.

6. Diversity, equity, inclusion, and accessibility, including for immigrant children, parents, and families in Oregon, are central to our work and to our membership. FFO believes that solutions related to early childhood education and the childcare system must actually work and be accessible to everyone, including those who are the most vulnerable and underserved. FFO believes that, when we find solutions that are based on equity and dignity for those in our communities most impacted by harmful conditions, we create benefits and equity for all of us.

7. FFO co-leads the Child Care for Oregon coalition of nonprofit organizations, labor unions, community advocates, parents, caregivers, and providers working to build a universal and publicly-funded childcare system that is community-led, equitable, affordable, culturally relevant, inclusive, developmentally appropriate, and safe, and that supports every child's early education, learning, and development. The coalition represents constituencies that are disproportionately impacted by Oregon's disconnected and under-resourced childcare system, including women, parents, and childcare providers who are Black, Indigenous, Asian, refugees, immigrants, Latinx, rural area residents, and/or low-income.

8. Through the Child Care for Oregon coalition, FFO and its partner organizations provide opportunities for parents, childcare providers, and community members to ensure that

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their perspectives are included in campaigns fighting for increased access to and funding for early education and childcare, including through story-telling efforts, direct actions, advocacy, and an activist summit for parents, providers, and community members to share their lived experiences and build advocacy skills.

9. FFO also has a sister organization, known as Family Forward Action, which works with mothers and caregivers to advocate for stronger statewide programs and laws to support the economic well-being and power of Oregon families.

10. FFO maintains an organizational structure designed to center the voices of Oregon mothers and caregivers, and particularly those who have been most impacted by racial, gender, and class disparities in care systems, in its internal decision-making processes. This structure is designed to ensure that the lived experiences of parents and caregivers, particularly those from vulnerable and marginalized backgrounds, guide FFO's priorities and strategic decisions. FFO's Board of Directors also is comprised of parents, caregivers, and community members who represent the communities that FFO serves.

11. FFO engages with over 15,000 individuals through its listserv and other means of participation, including mothers and caregivers, childcare providers, and other community members who are dedicated to increasing access to early education and childcare in Oregon.

12. Roughly half of our members self-identify as immigrants and/or as having mixed-status households.[2] FFO's immigrant members include parents and caregivers of children who are currently enrolled in and rely on early education and childcare services provided by Head Start programs in Oregon.

13. Many of FFO's immigrant members have limited English proficiency, including monolingual Spanish speakers. To support these members, FFO has a bilingual

[2] The term "mixed-status households" refer to households that are comprised of members who are U.S. citizens and members who are non-U.S. citizens.

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Spanish/English organizing program to engage and educate these members on how the government works, particularly related to access to childcare and early education services. FFO also employs a Bilingual Statewide Organizer to support these members and ensure that they can participate in FFO's summits, monthly action team meetings, and other efforts, and to assist them with enrolling in and/or navigating Head Start and other early education and childcare programs.

14. FFO also coordinates two action groups made up mostly of immigrants and members of mixed-status families. These groups support parent engagement, empowerment, and skills-building through programs and activities, such as leadership development trainings, civic education, and distribution of information and resources.

15. FFO provides translation services at many of its meetings, trainings, and programs to ensure that its immigrant members, including those who have limited English proficiency, are able to participate fully. In addition, FFO provides its members with translated written materials and information at meetings and activities, as well as on its website.

16. FFO hosts other types of activities and programs to support its parent and caregiver members. In 2025, for example, FFO organized a care summit to provide leadership development and engagement opportunities for its parent, caregiver, and educator members of diverse backgrounds and experiences. Of over 60 members who attended the care summit, 75 percent identified as Black, Indigenous, or other people of color; more than 50 percent identified as monolingual or bilingual Spanish speakers; roughly 50 percent identified as immigrants; and 16 percent were from rural communities. The care summit specifically focused on engaging and mobilizing members around access to early education and childcare, guaranteed income, access to mental healthcare, and revenue dedicated to early learning and childcare services.

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17. Additionally, FFO organizes a statewide parent cohort comprised of five parents from communities most impacted by the childcare crisis in Oregon, including women of color, parents with disabilities, parents of children with disabilities, and low-income parents.

18. Immigrant parents and caregivers, as well as their children and families, are a central part of FFO's membership and to our mission of ensuring that all low-income children and families in Oregon have access to high-quality and affordable early education and childcare, including through Head Start.

II. The Importance of Head Start for Family Forward Oregon's Members Who Are Immigrants and/or Have Mixed-Status Families

19. The Head Start program is critical for low-income children and their families in Oregon, and especially for FFO's members who are immigrants and/or have children and family members who are immigrants.

20. According to Upwardly Global,[3] immigrant women and families face unique and heightened barriers to accessing early education and care programs due to the more limited availability of culturally responsive options, such as programs that provide dual-language learning and other linguistically appropriate and accessible programs.

21. Because of this gap in early education programs for immigrant families, Head Start—and its commitment to providing linguistically and culturally appropriate services—is especially vital to our immigrant members. For example, Head Start programs help to ensure that our immigrant members with limited English proficiency can participate fully in their children's early education and learning, communicate with providers regarding any issues or concerns, and ensure that their children are in a safe and supportive environment.

22. In addition, access to Head Start is critically important to our members due to the increased financial barriers that immigrant parents and families face in accessing early

[3] Upwardly Global, *How to Advance Immigrant Women's Access to Childcare: Policy Brief*, Feb. 15, 2024, https://www.upwardlyglobal.org/news/news/how-to-advance-immigrant-womens-access-to-childcare-policy-brief/.

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education and childcare programs. According to the Immigration Research Initiative, 33 percent of immigrant workers make under two thirds of the median wage, as compared to 24 percent of U.S.-born workers.[4] As a result of these economic disparities and the staggering costs of childcare in Oregon, Head Start provides one of the only affordable early education and childcare options for our immigrant members.

23. In addition to ensuring that children can grow and thrive in supportive early education settings, access to Head Start enables many of our parent and caregiver members—and especially immigrant parents and caregivers—to work, attend school, enroll in vocational training programs, go to health and medical appointments and treatment, and otherwise provide for their families.

24. Based on my personal knowledge and experience working with Head Start agencies, community partners, and FFO members, it is my understanding that Head Start agencies have never asked about or screened for eligibility based on immigration status when enrolling children in their programs. I am not aware of any Head Start program denying enrollment to a child based on the immigration status of their parents, caregivers, or family members.

25. When FFO staff speak with members about Head Start and other early education and childcare options (whether during trainings or during one-on-one meetings), they are regularly asked by members about how immigration status affects a member's ability to enroll in the program. In fact, it is one of the most common questions that we receive from our members when discussing early education and childcare options.

26. FFO's members who are immigrants and/or have mixed-status households have expressed concerns that programs that screen for or collect information about immigration status may later share that information with law enforcement agencies or take other action that

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[4] Immigration Research Council, *Immigrants in the Oregon Economy: Overcoming Hurdles, Yet Still Facing Barriers*, May 1, 2024, https://www.ocpp.org/2024/05/01/immigrants-boost-oregon-economy/.

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may put them, their children, and/or their families at risk for increased scrutiny related to their immigration status or other negative consequences.

27. FFO staff have relied on Head Start's policy not to screen based on immigration status when discussing and sharing information about Head Start and other early education and childcare programs with FFO members.

28. Based on Head Start's policy not to screen based on immigration status, FFO's members have enrolled their children in Head Start, and have trusted Head Start programs to be safe and supportive learning environments for their children. Also, because of this policy, Head Start agencies have been able to build trust with and effectively engage in outreach with FFO parent and caregiver members and the broader community.

III. Defendants' Attacks on Head Start and Resulting Harms to Family Forward Oregon and Its Members

a. Defendants' Attacks on Head Start

29. I am aware that on July 14, 2025, the U.S. Department of Health and Human Services ("HHS") issued a notice entitled "Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of 'Federal Public Benefit'" ("July 14 Immigrant Exclusion Directive"). I understand that this Immigrant Exclusion Directive went into effect on July 14, 2025.

30. I understand that the Immigrant Exclusion Directive redefines Head Start as a "federal public benefit" under the PRWORA and excludes certain immigrants from Head Start based on immigration status.

31. I understand that only immigrants with specific legally defined immigration statuses are "qualified" to receive federal public benefits under federal law.

32. However, I understand that various aspects of the Immigrant Exclusion Directive leave many unanswered questions. For example, it does not specify whether eligibility for Head Start will be determined based on the immigration status of the child, the

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parents and/or guardians, or family and/or household members, or provide clear guidance on how Head Start programs should implement this new Directive.

b. Harms for Family Forward Oregon's Parent and Caregiver Members

33. Because of the new Immigrant Exclusion Directive, many Oregon parents and caregivers, including FFO's members, may lose access to the Head Start programs on which they rely for early childhood education solely based on immigration status.

34. In addition, because of the new Immigrant Exclusion Directive, many of FFO's parent and caregiver members will be scared to attend, participate in, or enroll in Head Start programs out of fear and confusion about the Rule and its impacts for themselves, their children, and their families.

35. Many immigrant parents and caregivers do not know or are unsure about their immigration status or the immigration status of their children and/or family members, as defined under federal law. Many of our parent and caregiver members also are not familiar with the PRWORA or federal immigration law. Because of this, many of our members do not know or are unsure about which specific immigration statuses qualify them as "eligible" for federal public benefits under federal law.

36. Because of the new Immigrant Exclusion Directive, many of our parent and caregiver members will be forced to stop attending or to not enroll their otherwise-eligible children in Head Start programs out of fear that they and their family members will be subjected to greater scrutiny and monitoring based on immigration status, that their information will be shared with law enforcement and immigration enforcement agencies, that participation may deem them a "public charge" or otherwise negatively impact their or their family members' immigration status, or that they could face civil and criminal penalties.

37. Losing access to Head Start means that many young children will experience sudden and major disruptions to their early childhood education and learning, as well as the loss of a safe and stable environment to learn, grow, and develop. These disruptions will have

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devastating effects on young children's development, mental and physical health, self-esteem, sense of stability, and overall well-being. This is especially true for children with disabilities and who are experiencing developmental delays, who rely on Head Start programs for additional supports and interventions.

38. Without access to Head Start, many of these children and their families also will lose access to affordable childcare options. As a result, many of our members will be forced to miss work, lose their jobs, disenroll from school or vocational training programs, and otherwise be unable to provide for and take care of themselves and their families. Loss of childcare access may have further impacts on our members' ability to pay their rent, utility bills, grocery bills, and other expenses, and could lead to housing insecurity and homelessness for many members. It will also mean that our members will face increased barriers to getting to medical and healthcare appointments and otherwise accessing medical treatment due to lack of childcare.

39. Head Start also encourages our parent and caregiver members to take an active role in their children's education and development through various parent involvement opportunities, such as volunteering in the classroom, attending parent-teacher conferences, and participating in decision-making. Head Start also provides parent education and training opportunities, helping our members to develop important parenting, education, and job readiness skills and to improve their economic, physical and psychological well-being and self-sufficiency. Exclusion from Head Start will mean that these opportunities will no longer be available to our immigrant members and could negatively impact parent-child relationships.

c. Harms to Family Forward Oregon Based on the Immigrant Exclusion Directive

40. In addition to the harms on our parent and caregiver members, the new Immigrant Exclusion Directive will directly harm FFO by frustrating our mission to advance access to early education and childcare for low-income children and families in Oregon, diverting our limited staff time and resources from existing and pre-planned core activities

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toward rapid response efforts, and interfering with our ability to carry out our existing work and activities.

41. The Head Start program is a vital component of FFO's mission and efforts to promote economic inclusion and secure broader access to high-quality, equitable, and culturally relevant early childhood education, learning, and childcare for mothers and families in Oregon, and especially for our members who are immigrants and/or have children and family members who are immigrants. The exclusion of immigrant children and families from Head Start caused by the new Directive will not only harm these members, but also directly undermine our mission and ongoing efforts to increase access to early childhood education and childcare across the state. It also will perpetuate the undervaluing of care and caregivers, exacerbate the existing early education and childcare crisis, and further entrench systemic disparities in health, educational, and economic outcomes for immigrant children and families—all of which are conditions that are central to FFO's mission.

42. The exclusion of immigrant children and families from Head Start will also directly harm and interfere with FFO's planned activities to organize and empower parent and caregiver members through monthly membership meetings, direct actions, summits, cohorts, and other events. Because many of our immigrant members rely on Head Start for childcare, losing access to Head Start will limit those members' ability to attend, participate in, or otherwise engage in our programs and activities—thereby directly interfering with our ability to conduct our work.

43. The Immigrant Exclusion Directive also will force FFO to divert its already-limited staff and organizational resources from existing work and activities toward rapid response efforts and increased inquiries related to the Directive and its impacts on our members. For example, our staff will be forced to dedicate significant time and resources to responding to concerns and questions from FFO parent and caregiver members, FFO childcare provider members, community partners, and other stakeholders regarding the Immigrant

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Exclusion Directive. This is especially true for our Bilingual State Organizer, who serves as our primary liaison with Spanish-speaking and immigrant members, and who will be forced to divert her time away from pre-planned work toward responding to inquiries and otherwise supporting our members in understanding the Immigrant Exclusion Directive.

44. Since the Department of Health and Human Services announced its intention to issue the Immigrant Exclusion Rule on July 10, 2025, FFO has experienced an increase in outreach and inquiries from parent and caregiver members, caregiver members, community partners, and other stakeholders about the Directive and its impacts. In fact, our staff have already spent significant time responding to inquiries about the Directive, diverting time and resources away from previously scheduled activities.

45. In addition to forcing our staff to divert resources from existing work, the Immigrant Exclusion Directive will force FFO to expend additional resources on translation services to put together and distribute information and materials about the Directive and its impacts in multiple languages so that they are accessible to our members who are immigrants and/or have mixed-status households.

46. Moreover, FFO will be forced to divert its limited resources away from its core and pre-planned operating activities toward addressing the immediate harms of Defendants' actions on its members. For example, FFO will be forced to expend its limited financial resources on covering costly childcare services so that its immigrant parent and caregiver members can continue to attend and participate in FFO meetings, events, and activities. FFO also will be forced to expend additional staff time and resources organizing trainings, meetings, and other actions to educate our members about and otherwise respond to the Directive and its impacts.

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I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 21, 2025

/s/ Candice Williams

Candice Williams

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The Honorable Ricardo S. Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

WASHINGTON STATE ASSOCIATION OF HEAD START AND EARLY CHILDHOOD ASSISTANCE AND EDUCATION PROGRAM, ILLINOIS HEAD START ASSOCIATION, PENNSYLVANIA HEAD START ASSOCIATION, WISCONSIN HEAD START ASSOCIATION, FAMILY FORWARD OREGON, and PARENT VOICES OAKLAND,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of the Administration for Children and Families; ADMINISTRATION FOR CHILDREN AND FAMILIES; OFFICE OF HEAD START; and TALA HOOBAN, in her official capacity as Acting Director of the Office of Head Start,

Defendants.

Case No. 2:25-cv-00781-RSM

DECLARATION OF MARTHA ZASLOW, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

NOTE ON MOTION CALENDAR: JUNE 13, 2025

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I, Martha Zaslow, hereby declare:

1. I am currently an independent child development research consultant. I have spent my entire career focused on research, practice, and policy related to childhood development. I received my Ph.D. in Personality and Developmental Psychology from Harvard University in 1978. I then worked as a researcher at the National Institute of Child Health and Human Development of the National Institutes of Health, followed by serving as a consultant for the Committee on Child Development Research and Public Policy at the National Academy of Sciences and for the Carnegie Council on Adolescent Development. From 1993 to 2009, I worked in a variety of roles at a national research organization focused on designing, conducting, interpreting, and communicating rigorous, high-quality research on children's development. I retired four years ago after working in leadership positions at a membership association of child development researchers dedicated to advancing developmental science. I currently serve as a consultant on child development research projects with a particular focus on early development.

2. From 2010 to 2012, I was appointed to serve on the Advisory Committee on Head Start Research and Evaluation of the U.S. Department of Health and Human Services. I have served on numerous other committees or panels focusing on rigorous research in early childhood development and its use to inform early childhood practice and policy, including serving as an appointed committee member for the National Academies of Science, Engineering and Technology consensus committees on Developmental Outcomes and Assessments for Young Children. I have also served on technical working groups for the development of national surveys of early childhood care and education and for the development of measures of quality in early childhood care and education settings.

3. I have been the author or co-author since 2005 of 41 publications presenting original research and analyses of theoretical and methodological issues in child development research; 25 research, practice and policy briefs; and two compendia providing detailed

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summaries of child development studies. I have co-edited two volumes of child development research; and been a contributor as a committee member to two books and federal reports.

4. Attached as **Exhibit A** to this Declaration is a true and correct copy of my curriculum vitae.

Background on the Head Start and Early Head Start Programs[1]

5. Launched in 1965 as part of the War on Poverty, the Head Start program "is a comprehensive, national, and federally funded program that provides early childhood developmental services to disadvantaged children" ages 3 through 5 "and their families. Federal guidelines state that at least 90% of the children enrolled in each of the Head Start centers must be from families whose total annual income before taxes is less than or equal to the poverty line and at least 10% of the participants must be children with disabilities" (Anderson, Foster & Frisvold, 2010, p. 588).

6. The Early Head Start program, launched as part of the 1994 reauthorization of the Head Start Act, "was designed based on growing empirical evidence of the importance of the first three years of life for children's neurological and brain development…." It "is a primary prevention program offering services to an at-risk…population of low income families including pregnant women and families with children through age three years." Like the program for older preschool-age children, all Early Head Start programs "must follow the high standards for comprehensive services for families (including education, nutrition, health and mental health) set by the Head Start Performance Standards…but can be designed to fit the needs of local communities. Programs can offer child care, home visiting or a mixture of the two services" (Green et all, 2020, Program overview, first paragraph).

7. Head Start addresses children's development in the early years when there is evidence both of particular malleability in development and the potential for long-term

[1] In this document, the terms "Head Start program" and "Early Head Start program" will be used when the focus is specifically on these separately. The term "Head Start" without the word "program" will be intended to encompass all Head Start programs.

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influence. Research suggests that the earliest years of life are a particularly promising time to intervene in the lives of low-income children, both because of relatively high neurodevelopmental plasticity during that time (Ludwig & Miller, 2007; Ludwig & Phillips 2008), and because "[t]here is… strong evidence that early childhood socioeconomic conditions have long-term economic consequences, reinforcing and sustaining disparities over the life course" (Anderson, Foster & Frisvold, 2010, p. 587).

Head Start's "Whole Child" Approach

8. Head Start takes a "whole child" approach, providing supports for multiple aspects of development, building on an understanding that these aspects are all important for subsequent development and that they have complementary and mutual influences. This means that Head Start, while clearly focusing on cognitive development, also aims to strengthen children's health, social and emotional development, and the parent-child relationship. This sets it apart from early childhood programs that focus solely or primarily on cognitive development.

9. Because it is "based on a 'whole child' model," Head Start "…provides comprehensive services that include preschool education; medical, dental and mental health care; nutrition services, and efforts to help parents foster their children's development" (U.S. Department of Health and Human Services, 2010a, Introduction, first paragraph).

10. Anderson, Foster and Frisvold (2010) underscore the distinctive nature of Head Start as comprehensive, targeting multiple aspects of development in this way: "Increasing the cognitive achievement of the disadvantaged children in the Head Start program is clearly an important goal. However, because of the comprehensive services provided in the program, greater cognitive ability is likely to be only one of many outcomes" (p. 589).

11. Ludwig and Miller (2007) viewed the early childhood education component as one of Head Start's six overall program components, accounting (at the time of publication) for approximately 40 percent of overall budget. The other major components include parent involvement, nutrition, social services to strengthen family life, mental health services, and health services. According to these authors, "this bundle of Head Start services might affect

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schooling through a variety of causal channels. In addition to the direct effects on schooling from early childhood education, nutrition and health services, Head Start may indirectly affect children's schooling by influencing parents' schooling attainment or parenting practices" (p. 166).

12. As an example of the potential of Head Start to have mutual and complementary influences, these researchers note that positive nutrition can affect other aspects of health, such as susceptibility to infectious diseases in childhood. We note that this in turn may result in higher attendance and actual participation in Head Start, which can augment the educational and further developmental benefits of the program.

Head Start Provides Services to Families, Not Just Children

13. A further distinctive feature of Head Start is its two-generation focus. Families participating in Head Start receive services aimed at strengthening parenting, health practices, parent psychological well-being and economic self-sufficiency.

14. Parents in Head Start work with a family support worker to articulate family goals and identify services in which to participate relevant to these goals within Head Start or in the community (Strassberger, 2024). As clearly indicated in each year's Program Information Report provided by the Office of Head Start, parents as well as children receive program services.

15. As selected examples of the services families receive, for the 2023-24 enrollment year, the Office of Head Start National Services Snapshot for All Head Start Programs[2] (Office of Head Start, 2023-24) indicates that nearly two thirds of families (65.4%) received services involving discussing their child's developmental screening and assessment results and their child's progress, and over a third (39.2%) received services involving participation with a research-based parenting curriculum. Health practices and nutrition were also a strong focus,

[2] The Office of Head Start National Services Snapshot for All Head Start Programs includes the Head Start, Early Head Start, and Migrant and Seasonal Head Start programs.

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with approximately half of families receiving services involving education on preventive medical and oral health (49.7%) and education on nutrition (46.9%), and 15.2% of families receiving services involving education on the health and developmental consequences of tobacco product use. Psychological well-being and economic self-sufficiency were also foci of services. For example,14% of families received mental health services and 11.4% received assistance enrolling in an education or job training program.

16. Head Start focuses on families and children in populations at particularly high risk. As noted, at least 90% of the children enrolled in each Head Start center must be from families with annual incomes at or below the federal poverty line. Analyses of data from a nationally representative sample of Head Start program families in 2019 provide a more detailed picture of the kinds of material hardship (inability to pay for basic needs) families participating in Head Start programs had experienced in the past 12 months. Approximately a quarter reported having unmet medical needs (29%), experiencing food insecurity (27%), having difficulty paying for basic utilities (26%), and experiencing housing insecurity (23%). More than half reported facing at least one of these forms of material hardship over the past 12 months (Doran et al., 2021). The Office of Head Start Program Services Snapshot for enrollment year 2023-24 indicates that 26.6% of Head Start families received family support services focusing on emergency or crisis intervention.

17. Further, at least 10% of participants in Head Start must be children with disabilities. The 2023-24 Office of Head Start Program Services Snapshot for all Head Start programs indicates that this percentage was exceeded. For this enrolment year, 14.8% of children enrolled in Head Start programs were children with an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP), indicating they were determined eligible to receive special education, early intervention, and related services. It is noteworthy that in addition, 7.4% of children experiencing homelessness were served during the program year, and 3.2% of enrolled children were in foster care at some point during the program year.

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Evidence on the Short-Term Benefits of the Early Head Start and Head Start Programs

18. Evaluations of both the Early Head Start and Head Start programs have been carried out using rigorous experimental designs, that is, with families randomly assigned to be eligible or not eligible to participate in the program.

19. The Early Head Start impact evaluation was conducted with 17 of the first-funded programs, including center-based, home-based and mixed program models. 3001 children were randomly assigned to be eligible to participate in the Early Head Start program or to a control group. The study included waves of data collection when the children were 14 months, 24 months and 36 months (at the conclusion of eligibility). Follow-up data collected at kindergarten entry and grade 5 are discussed below. The evaluation included direct assessments as well as reports of children's development and observations of parent-child interactions (U.S. Department of Health and Human Services, 2002).

20. The evaluation of the Early Head Start program found benefits across a range of measures of children's development and parents' behaviors (both parenting and economic self-sufficiency behaviors) through the end of program eligibility. Focusing on the findings when the children were age 3:

- Early Head Start children scored higher on the Bayley Scales of Infant Development Mental Development Index, with a smaller percentage scoring in the at-risk range. Early Head Start children also scored higher on the Peabody Picture Vocabulary Test (PPVT-III), an assessment of receptive vocabulary, with fewer children scoring in the at-risk range for this measure as well. Children were rated by their parents to be lower in aggressive behavior than control group children.
- Direct observations of parent-child interaction found that Early Head Start children more often engaged with their parents, less often showed negative behavior towards their parents, and were more attentive to objects during play,

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and that parents were more emotionally supportive during interactions.

- Early Head Start parents scored higher on a measure of how supportive and stimulating the home environment was for their children (Home Observation for Measurement of the Environment), including findings for a subscale indicating that Early Head Start families provided more support for language and learning in the home. Early Head Start parents were more likely to report reading daily to their children and less likely to report having spanked their children in the past week. Early Head Start parents were less detached and less likely to engage in negative parenting behaviors.
- Early Head Start parents showed more participation than control group parents in education and job training activities, and a higher percentage of program group parents were employed at some time during the follow-up through age 3.
- In a subset of 12 of the 17 study sites, fathers also participated in the evaluation. During observed interactions, Early Head Start fathers were less intrusive when interacting with their children and children were more able to engage their fathers during play. Fathers reported spanking their children less often and also reported participating more often in child development-related program activities.

21. In summarizing the program's short-term impacts, Vogel and colleagues (2010) note that "at the end of the program, when children were 3, Early Head Start was found to benefit families across a wide range of child parent and family self-sufficiency outcomes, although impacts were modest in size and Early Head Start children continued to perform below national norms on cognitive and language assessments" (p.8).

22. A rigorous evaluation of the Head Start program found positive impacts on a range of measures of children's development at the end of a year of eligibility for Head Start, both for children who were newly eligible to participate in Head Start as 3- and as 4-year-olds.

23. The Head Start impact evaluation was carried out in a nationally representative

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sample of 84 grantee/delegate agencies. Approximately 5,000 newly entering eligible 3- and 4-year-olds were randomly assigned to a program group with access to the program, or to a control group that did not have access to the program but could enter other non-Head Start early care and education services. The Impact Study Final Report (U.S. Department of Health and Human Services, 2010a) is careful to note that about 60% of control group children participated in some form of early care and education. This makes it possible to ask whether the quality of early care and education differed for those participating in such settings in the program vs. control groups. At the same time this means that the contrast across groups is not one of the Head Start program vs. no early care and education. In addition, the evaluation does not consider one vs. two years of eligibility for the Head Start program for the 3-year-old group, but instead an earlier year of eligibility for the Head Start program.

24. According to the Final Report of the Impact Study (U.S. Department of Health and Human Services, 2010a), at the conclusion of one year of eligibility to participate in the Head Start program:

- In the spring of the first year of the study (at the conclusion of the year of Head Start program eligibility), having access to the Head Start program meant that children experienced higher quality early care and education across a wide range of measures, including teacher qualifications, engagement in instructional activities, teacher-child ratio, and observed measures of teacher-child interaction using the Early Childhood Environment Rating Scale-Revised (Harms et al., 1998).
- For the 4-year-old cohort, there were significant positive impacts on six direct assessments of children's language and literacy development, and parents reported that their children had stronger emerging literacy skills. In addition, access to the Head Start program increased children's receipt of dental care.
- For the 3-year-old cohort, there were positive impacts on five direct assessment measures of children's language and literacy development as well as on measures

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of math skills and pre-writing skills. Parents also reported stronger emerging literacy skills for their children. For this cohort there were also impacts on social-emotional development. At the end of the Head Start year, children in the program group were reported by their parents to show fewer behavior problems overall and less hyperactive behavior. As in the 4-year-old cohort, having access to the Head Start program increased children's receipt of dental care. There was also moderate evidence of improved overall health as reported by parents at the conclusion of the Head Start year.

25. In summarizing program impacts at the conclusion of one year of eligibility to the Head Start program, the Final Report Executive Summary notes: "The study shows that providing access to Head Start led to improvements in the quality of early childhood settings and programs children experienced…These impacts on children's experiences translated into favorable impacts at the end of one year in the domains of children's cognitive development and health as well as in parenting practices. There were more significant findings across the measures within these domains for 3-year-olds in that first year (and only the 3-year-old cohort experienced improvements in the social-emotional domain.)" (U.S. Department of Health and Human Services, 2010b, p. xxiv).

Evidence on the Longer-Term Effects of the Early Head Start and Head Start Programs

26. There are suggestive trends but few statistically significant impacts of the Early Head Start and Head Start programs when children in the two impact study samples are followed into elementary school. Nevertheless, a growing body of rigorous research provides evidence that adults who had participated in the Head Start program as children show positive effects on a range of key indicators of adult functioning, such as educational attainment, economic self-sufficiency and health. Below are summaries of (1) the follow-up studies into elementary school conducted with the Early Head Start and Head Start impact study samples, and (2) of the accumulating body of evidence showing benefits of participation in the Head

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Start program into adulthood.

27. When a follow-up study was conducted in kindergarten and fifth grade with the Early Head Start Impact Study sample, while some differences remained at kindergarten entry, there was little indication of group differences in fifth grade:

- At kindergarten entry, Early Head Start continued to show impacts on children's social-emotional development, with decreased reported behavior problems. Children also showed more positive approaches toward learning. Early Head Start program group parents continued to show stronger scores on the measures of the home environment with more teaching activities and daily reading. Mothers were also at lower risk of depression (Love et al., 2013).
- However, "[t]he impact analyses show that for the overall sample, the positive effects of Early Head Start for children and parents did not continue when children were in fifth grade" (Vogel et al. 2010, p. 23). There was only one impact at the trend level on a summary index of children's social-emotional success, continuing the pattern of positive impacts in this area of development found at earlier ages. No impacts were found on academic outcomes, on parenting or family outcomes.

28. Similarly, few differences remained in outcomes in the follow-up study conducted with the Head Start Impact Study sample at the end of kindergarten and first grade:

- For the 4-year-old cohort, there were no impacts in the cognitive domain at the end of kindergarten, though there was a trend suggesting more positive vocabulary scores in first grade. There were no differences on measures of social-emotional development during kindergarten. In first grade, children in the Head Start program mgroup in the 4-year-old cohort were rated by teachers as tending to be more socially reticent (in contrast with parents' reports that their children tended to show less withdrawn behavior) and teacher reports were also suggestive of more problematic teacher-child relationships. In kindergarten,

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those in the 4-year-old cohort in the Head Start program group showed suggestive evidence of improvement in health status, and trends also pointed to more health insurance coverage in both kindergarten and first grade (U.S. Department of Health and Human Services, 2010a).

- For the 3-year-old cohort, there was no strong evidence of impacts on language or literacy at the end of kindergarten or first grade, though there was some suggestive evidence of a positive impact on oral comprehension at the end of first grade. At the end of the kindergarten year, there was a suggestive pattern in which parents of children in the Head Start program group in the 3-year-old cohort reported that their children tended to have better social skills and less hyperactive behavior as well as more positive approaches to learning, however teachers assessed math ability less positively for the children in the Head Start program group. By the end of first grade, parents of Head Start children in this cohort tended to report a more positive relationship with their child. Children in this cohort also tended to have more health insurance coverage (U.S. Department of Health and Human Services, 2010a).

29. Thus, both impact studies point to a pattern of convergence on outcomes for children in the program and control groups during the early school years. Despite this pattern, as noted earlier, when researchers use analytic approaches involving examining outcomes in adulthood in light of Head Start program participation during childhood, there is accumulating evidence of long-term benefits of participation in Head Start. These analyses generally reflect on the Head Start program rather than the Early Head Start program because this was the program in existence during the childhoods of the adult study participants. Researchers in these studies have used rigorous econometric approaches, for example, contrasting outcomes in adulthood for siblings who had or had not attended Head Start in childhood in longitudinal survey data, and looking at key adult outcomes in counties according to whether, as children, the survey participants were age-eligible or age-ineligible for Head Start before and after the

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introduction of the program.

30. Regarding the evidence from these studies through 2012, the Advisory Committee on Head Start Research and Evaluation concluded that:

> These nonexperimental studies of Head Start[3] capitalizing on longitudinal data and employing rigorous econometric analyses suggest that Head Start does confer a long-term advantage in adolescence and early adulthood when young persons face new developmentally challenging tasks. Taken together, there is evidence of long-term positive outcomes for those who participated in Head Start in terms of high school completion, avoidance of problem behaviors, avoidance of entry into the criminal justice system, too-early family formation, avoidance of special education, and workforce attachment. These and other findings also point to economic benefits of Head Start over the initial cost of the program. (p.33)

31. Some researchers hypothesize that even the small remaining differences found in elementary school in the impact study samples may be of sufficient magnitude to convey benefits into adolescence and adulthood (Ludwig & Phillips, 2008). As noted earlier, researchers also point to the potential complementarity of effects (Ludwig & Miller, 2007). Small remaining effects across multiple aspects of development may accumulate or interact to convey benefits into adulthood. It is also possible that early program impacts on parents' economic self-sufficiency and on how parents view their children's skills and behaviors (for example, the difference in parent perception of the children's early literacy skills in the Head Start Impact Study noted above), have enduring implications.

32. Studies published since the review of the Advisory Committee in 2012 have

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[3] The use of the term "nonexperimental" here indicates that these studies do not involve random assignment of study participants to treatment and control groups. The Head Start and Early Head Start impact studies used random assignment to select families to be either eligible or not eligible to participate in the program.

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continued to provide evidence of effects of the Head Start program into adolescence and adulthood. Examples of findings from the more recent studies include the following:

33. Schanzenbach and Bauer (2016) contrast long-term outcomes for siblings who did and did not participate in the Head Start program in the National Longitudinal Survey of Youth-Child Supplement sample (the data for children of the initial respondents), considering Head Start program participation during a more recent period than the focus of earlier studies reviewed by the Advisory Committee on Head Start Research and Evaluation. These researchers find that Head Start increases participation in higher education by between 4 and 12 percentage points, while also resulting in an overall increase in postsecondary credential completion, defined as including a license or certificate, an associate's degree, or a bachelor's degree.

34. Bailey, Sun and Timpe (2021) improve on previous studies through linking data on exact date and location of birth (rather than relying on reported measures) for a large census data sample. Analyses look at county rollout of the Head Start program, contrasting data for children eligible to participate in Head Start when it launched (ages five and younger) or age six (over the age cutoff). Results indicate that Head Start program participants:

- participated in .65 more years of education,
- were 2.7 percent more likely to complete high school, and
- were 8.5 percent more likely to enroll in college, with college completion rates increasing 39%.

35. In addition to considering educational attainment, Bailey, Sun and Tempe (2021) also examined measures of economic self-sufficiency. Looking at adult outcomes they find Head Start participants:

- to be 5.3 percent more likely to have worked in the previous year,
- to have worked 2.3 weeks more in the previous year and 3 more hours per week on average.

36. In addition, they find evidence that participation in the Head Start program

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reduced the likelihood of adult poverty by 23 percent and receipt of public assistance income by 27 percent.

37. Deming (2009) had reported earlier that Head Start participants were less likely in adulthood to be idle, defined as not being in school and not reporting wages. More recent work by Carneiro and Ginja (2014) focusing on males also finds a difference according to Head Start participation for idleness at ages 20-21.

38. Morrisey (2019) notes that there is a growing body of evidence indicating that early care and education programs in general have effects on children's health, and that Head Start is particularly important to consider in this context because unlike other early childhood programs it has an explicit focus on providing nutrition and health services. Morrisey's review of research on the health effects of early care and education includes two more recent studies focusing specifically on the Head Start program. Carneiro and Ginja (2014) found that that for males, Head Start reduced the likelihood of being obese and having a health condition requiring the use of special equipment at ages 12 and 13, while reducing obesity at ages 16-17. The Morrisey summary also points to findings from Thomspon (2018) indicating that Head Start participants were less likely to have a health condition at age 40. These more recent studies complement and extend earlier work showing effects on smoking (Anderson et al., 2010), percent in poor health (Deming, 2009), and mortality (Ludwig & Miller, 2007).

39. The long-term effects of Head Start on such outcomes as increased long-term earnings and decreased smoking have contributed to analyses indicating that Head Start's economic benefits surpass its costs (Bailey et al., 2021; Anderson et al., 2010 respectively).

40. Ludwig and Miller (2007) note that the timing of data collection for the studies of effects in adulthood necessarily consider children's participation in Head Start as it operated decades earlier. They note that there have since been improvements to the Head Start program, which could mean that the estimates of long-term benefits are conservative. Yet they caution that the experiences of children who did not participate in Head Start may have changed for the

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better over time as well, as other early childhood programs, such as state sponsored pre-kindergarten, expanded.

41. Timing of data collection is also important to keep in mind for the Early Head Start and Head Start Impact Studies. The former was initiated soon after the launch of the Early Head Start program with 17 of the first-funded sites. Data collection for the Head Start Impact Study started in 2002 and continued through 2006. Subsequent data on nationally representative samples of both Head Start and Early Head Start programs indicate that there have been program-wide improvements on key measures of quality (see summary of this evidence below). Evidence for sustained impacts into the school years might therefore also be stronger for children who participated in Head Start and Early Head Start programs more recently. Here again though, the caution raised by Miller and Ludwig about expanding options for early care and education for children not participating in Head Start in more recent years is relevant.

Head Start's Monitoring and Quality Improvement Processes

42. The Advisory Committee on Head Start Research and Evaluation (2012) concluded that "Head Start has been and continues to be a leader…in its commitment to accountability for program quality" (p.2).

43. The Committee noted that Head Start has built:

> an infrastructure to support quality, an effort for which there was little precedent. Head Start published its first set of Program Performance Standards in 1974, along with implementation of a rigorous on-site monitoring process for ensuring that standards were being met. Head Start Program Performance Standards (Performance Standards) have been revised several times with an increasing emphasis on the quality of services for children and families. Head Start has also provided training and technical assistance (T/TA) to support programs in providing professional development to staff members and program managers, and in remedying deficiencies in quality. Further, Head Start has expanded accountability to include replacement of grantees that were unable or unwilling

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to provide high quality services and sound management practices. (p.2)

44. This focus on quality is particularly important in a program that prioritizes serving children and families who experience instability due to such issues noted above as homelessness and placement in foster care, or who are experiencing ongoing financial stress.

45. Reports on program quality for nationally representative samples of Head Start and Early Head Start programs provide examples of two key patterns: (1) They have documented that a large national program, implemented at scale, can show significant improvements in program quality over time when this combination of training and technical assistance supports, clear standards, and monitoring are in place; and (2) The reports consistently identify next steps for improving quality, reflecting a view of quality improvement as an ongoing process.

46. One key example of evidence of improvements in quality in a national program implemented at scale is provided in the report *Tracking quality in Head Start classrooms: FACES 2006 to FACES 2014* (Aikens et al, 2016). As part of recurring data collection in nationally representative samples of Head Start programs, classrooms and families for the Family and Child Experiences Survey in Head Start (FACES), classroom quality was observed in Head Start program classrooms in 2006, 2009 and 2014 (and subsequent to this report, has continued to be observed periodically). The observations of classroom quality in a nationally representative sample of Head Start program classrooms were conducted using two widely used measures of quality in early childhood classrooms: The Early Childhood Environment Rating Scale-Revised (ECERS-R; Harms et al., 1998), and the Classroom Assessment Scoring System for Pre-kindergarten (CLASS Pre-k; Pianta et al., 2008).

47. Results indicate that:

- Average scores on two of the key factors on the Early Childhood Environment Rating Scale-Revised, Provisions for Learning and Teaching and Interactions, improved significantly, both between 2006 and 2014.
- Average Scores also improved on the Classroom Assessment Scoring System for

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Pre-kindergarten Instructional Support domain between 2006 and 2014.

- There was also progress in terms of diminished proportions of classrooms scoring in a low range and increased proportions of classrooms scoring in a good- or excellent-range according to publisher-developed cut points on each of these measures. For example, between 2006 and 2014 fewer classrooms scored in the inadequate- and minimal-range and more in the good- or excellent-range for the Provisions for Leaning and the Teaching and Interactions factor scores on the Early Childhood Environment Rating Scale-Revised. On the Classroom Assessment Scoring System, between 2006 and 2014, fewer classrooms scored in the low range and more in the mid- to high- range on Instructional Support.

48. Key indicators of quality in the Early Head Start program also show improvements over time in nationally representative samples. A 2024 report provides illustrations not only of quality improvement but also of the articulation of where to focus further improvement efforts (Baxter et al., 2024).

- Using the Quality of Care for Infants and Toddlers (QCIT) measure (Atkins-Burnett et al., 2015) in Early Head Start classrooms, this study found that in 2022, nearly all classrooms (96%) were providing either mid- or high- levels of social and emotional support, and that there was a significant increase over time from 2018 to 2022 in the percent of classrooms providing high levels of social and emotional support (from 19% to 32%).
- This study found that most classrooms (83%) were providing either mid- or high-levels of support for language and literacy development in 2022, with no significant change from 2018.
- However, in 2022, 57% of classrooms were found to be providing mid-levels of support for cognitive development with only a small percentage providing high-levels of support in this area, and 41% providing low levels (also with no changes from 2018).

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- The report concludes that attention should be considered to providing professional development for teachers of infants and toddlers in the area of stimulation for cognitive development.

49. For Early Head Start programs providing a home-based model, which involves weekly home visits as well as periodic group socialization rather than participation in center-based early care and education, between 2018 and 2022 there was a statistically significant increase from 65% to 76% in the percentage of families who followed through on home visits, completing all of the activities, discussions and referrals that were covered in the last home visit (Baxter et al., 2024).

50. These periodic studies of nationally representative samples of Head Start and Early Head Start programs also include surveys of program directors, center directors and teachers that regularly provide information not only about reported indicators of quality, such as staff educational attainment and ongoing professional development, but also reflect the ongoing participation of programs in monitoring and quality improvement and by providing information about the areas in which the staff would most appreciate support for quality improvement. As examples, in 2022, center directors indicated that 88.4% of their centers had been inspected or monitored for quality in the past 12 months and that 72.3% of centers were participating in a state or local Quality Rating and Improvement System (a system that provides summary ratings of quality to inform consumer choice and provide updates for policymakers and the public about early care and education in a geographical area). The top three areas in which center directors indicated a need for additional support to lead more effectively were program improvement planning, staffing and hiring, and working with and partnering with the community (Doran et al, 2022). The recent Information Memorandum from the Office of Head Start (April 2025) encourages the participation of Head Start programs in Quality Rating and Improvement Systems and underscores the importance of parent input in the process of program improvement.

51. Regarding the importance of adherence to Head Start Program Performance

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Standards, a noteworthy example comes from the Early Head Start impact evaluation (U.S. Department of Health and Human Services, 2002). As noted earlier, this evaluation was conducted among a group of 17 of the first Early Head Start programs. These programs were found to vary according to whether the programs had implemented the Head Start Program Performance Standards for Early Head Start early on during the evaluation period, later during the evaluation period, or as yet incompletely. The evaluation found that "[i]mplementing key elements of the Head Start Program Performance Standards fully is important for maximizing impacts on children and parents" (U.S. Department of Health and Human Services, 2002, p, 6).

Head Start as a Leader for Early Care and Education Programs Nationally

52. The Advisory Committee on Head Start Research and Evaluation (2012) concluded that "the Head Start program has provided leadership to the early childhood field in many…ways" (p.3).

53. As one key example, the Advisory Committee highlighted the role of the Performance Standards in calling for increases in professional development for teachers in Head Start, noting the influence such increases have had on the early childhood field overall:

> In 1972 Head Start initiated development of the Child Development Associate (CDA) credential, with the goal of increasing the competency of Head Start teachers. The CDA soon became a foundation for professional development in Head Start and in the ECE [early childhood education] community at large. The CDA continues to serve as a valuable entry certification for early childhood teachers, as Head Start has continued to raise the bar by requiring all teachers to possess associate and/or bachelor's degrees in child development or ECE. (pp. 2-3)

54. The studies tracking changes in quality document the increases over time in Head Start teachers' qualifications and professional development activities. For example, between 2006 and 2014 there was a significant increase in nationally representative samples of Head Start program classrooms in the percentage of classrooms with a teacher with a bachelor's

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degree or higher, from 40% in 2006 to 70% in 2014 (Aiken et al., 2016).

55. These studies also examine the linkage between increases in teacher education and observed classroom quality. In this study, the increase in the percentage of teachers with a bachelor's degree helped to some extent to explain the improvement in observed CLASS Instructional Support. More specifically, "whether the teacher has at least a bachelor's degree explains approximately 12 percent… of the increase in CLASS Instructional Support scores" (Aikens et al., 2016, p.8).

56. In light of the commitment of the Head Start program nationally to higher education for its teachers, it is noteworthy that the consensus committee convened by the National Research Council to develop a report on "Transforming the workforce for children birth through age 8: A unifying foundation" (National Research Council, 2015) recommended that the early childhood field as a whole move towards requiring all early childhood teachers to have a bachelor's degree with specialized knowledge in early childhood.

57. Head Start has also served in a leadership role in providing a framework for the development and evaluation of quality improvement steps that involve enhanced program models. Evaluations of programs that have built on but gone beyond the Head Start Program Performance Standards for both Early Head Start (the Educare program; Yazijan et al. 2020; Horm et all, 2022;) and Head Start (the Head Start CAP program in Tulsa Oklahoma; Phillip, Gormley & Anderson, 2016) provide evidence that (1) it is feasible to implement enhanced models at scale; and (2) such approaches show promise in terms of broader and more sustained impacts on child outcomes.

Cuts to Head Start Programming Will Have Immediate and Longer-Term Negative Effects on Children and Families and Will Have Implications for Early Care and Education in the United States More Broadly

58. **Reductions to Head Start Programming Would Immediately Harm Children and Families Through the Loss of Stable and Higher Quality Early Care and Education.** The evidence from the Head Start Impact Evaluation indicates that children in the

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Head Start program were receiving higher quality early care and education than children in the control group. Children's daily experiences matter particularly if they are experiencing the stressors of family economic hardship, homelessness, being placed in foster care or having a disability. The prevalence of such stressors for families and children currently participating in Head Start would mean that losing the stability and support of the program would be a loss felt immediately and daily both by children and by their families.

59. Reductions to Head Start Programming Would Mean Loss of the Programs' Short-Term Positive Effects on Children's Development and Family Functioning. Evaluations indicate that having access to the Early Head Start and Head Start programs results in a range of positive impacts on the development of children, on parenting behavior, and on families' economic self-sufficiency activities as the children transition from the program. Reductions in Head Start programming would mean the loss of this boost to children's health and development, families' participation in Head Start services, and improvements in family functioning.

60. Discontinuing the Program or Severely Hindering Program Functioning Would Mean Loss of Positive Effects on Longer-Term Outcomes Including Key Indicators of Adult Functioning. While the boosts in children's development and family functioning found at the conclusion of the program appear to wane during the school years, there is a growing body of evidence that participation in the Head Start program nevertheless has important benefits to functioning in adulthood. Studies show positive effects of Head Start program participation on such important areas of adult functioning as educational attainment, employment activities, and health. The benefits in adulthood on such key outcomes as earnings and reduction in smoking contribute to analyses indicating that Head Start is cost effective: that the economic benefits of the program to society outweigh its costs.

61. Reducing Program Functioning Would Negatively Affect Not Only Children and Families Participating in Head Start, But Early Care and Education Nationally. Head Start has provided leadership to other early care and education programs in the United States in

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requirements for teacher education, its approaches to supporting programs in ongoing efforts to improve quality, and in program monitoring. The Head Start Program Performance Standards provide a framework for programs seeking to further enhance program quality. Loss of the program or hindering program functioning would be a loss felt not only by Head Start programs and participating children and families but for early care and education in the United States.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed on May 14, 2025, at Bethesda, Maryland.

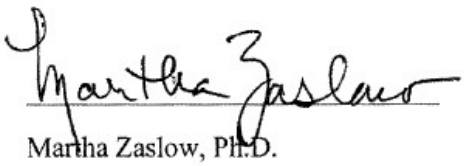

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EXHIBIT A

CURRICULUM VITAE
MARTHA ZASLOW

Martha Zaslow, Ph.D., is an independent child development research consultant. Her research focuses on effective approaches to strengthening quality in early childhood programs and on the professional development of the early childhood workforce. She has been asked to serve on multiple advisory committees and panels that focus on using research to inform early childhood practice and policy, including:

- Being appointed to the Advisory Committee on Head Start Research and Evaluation of the U.S. Department of Health and Human Services, which prepared a report for the Secretary assessing the existing research and providing recommendations for the highest priorities for future research focusing on Head Start.
- Serving as a Scientific Advisor for the Administration for Children and Families National Research Conference on Early Childhood, contributing to the planning of the research content at this biennial conference of researchers, policymakers and practitioners in early childhood.
- Leading the Research Advisory Group for the Evaluation of the Early Childhood Policy in Institutions of Higher Education (ECPIHE) project, which is piloting the introduction of graduate degrees and certificates focusing on early childhood policy in colleges and universities.
- Being appointed as a member of the National Academies of Science, Engineering and Technology consensus committees on Developmental Outcomes and Assessments for Young Children, which reviewed the evidence and made recommendations for the appropriate use of assessments for young children.
- Serving on the Advisory Board for the Early Childhood Education Institute, University of Oklahoma-Tulsa, participating in a periodic review of research conducted by this research center and providing input into next steps.
- Serving on the Technical Expert Panel for the Professional Development Tools to Improve the Quality of Infant and Toddler Care, helping to address the need for better measures of quality in settings for the youngest children.
- Serving on the Advisory Group, Saul Zaentz Early Education Initiative, Harvard Graduate School of Education helping to plan for rigorous research on early childhood initiatives in Massachusetts.
- Serving on the Advisory Committee for the Science and Technology Policy Fellowship Program of the American Association for the Advancement of Science, including helping to plan for an evaluation of their fellowship programs.
- Serving on technical working groups for the development and implementation of national surveys focusing on early childhood, including the Family and Child Experiences in Head Start (FACES), the FACES survey for Early Head Start (Baby FACES), and the National Survey of Early Care and Education.

EDUCATION

Cornell University, College of Arts and Sciences
B.A., Magna Cum Laude in Psychology, with Distinction in All Subjects, 1972
Harvard University, Department of Psychology and Social Relations,
Ph.D., Personality and Developmental Psychology, 1978

EMPLOYMENT

National Institute of Child Health and Human Development of the National Institutes of Health,
Staff Fellow, Child and Family Research Section, 1977-1984
National Academy of Sciences
Senior Research Associate/Consultant, Committee on Child Development Research and Public Policy, 1985-1990
Carnegie Council on Adolescent Development
Consultant, 1990-1992
Child Trends
Senior Research Associate, 1993-1995
Assistant Director for Research, 1995-2002
Content Area Director, Welfare and Poverty, 1999-2003
Program Area Director, Early Childhood Development, 2001-2009
Vice President for Research, 2002-2009
Distinguished Visiting Fellow, 2009 to present
Society for Research in Child Development
Director, Office for Policy and Communications, 2009 to 2016
Director for Policy, 2017 until retirement, May 2019
Interim Executive Director, July 2020-March 2021
Independent Child Development Research Consultant
Consulting on specific research projects, March 2021 to present

HONORS AND FELLOWSHIPS

Phi Beta Kappa
College Scholars Program, Cornell University
President, Women's Honors Society, Cornell University
United States Public Health Traineeship
Kent Fellowship, Danforth Foundation

PROFESSIONAL MEMBERSHIPS AND ACTIVITIES

Memberships

- Society for Research in Child Development

Board on Children, Youth and Families; National Research Council; National Academies of Science

- Member, Committee on Family and Work Policies

- Member, Committee on Developmental Outcomes and Assessments of Young Children, National Academies of Science
- Planning Group for Workshop on Early Years to Early Grades
- Planning Group for Forum on Investing in Young Children Globally

Manuscript Reviews

Ad hoc reviewer for: Child Development; Developmental Psychology; Early Childhood Research Quarterly; Maternal and Child Health Journal

PUBLICATIONS (From 2005)

Articles, Chapters and Reports on Original Research

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Zaslow, M., Tout, K., & Halle, T. (2012). On-site approaches to quality improvement in Quality Rating and Improvement Systems: Building on the research on coaching. Research-to-Policy, Research-to-Practice Brief OPRE 2012-40. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US DHHS.

Chien, N., Blasberg, A., Daneri, P., Halle, T., King, C., Zaslow, M., Fisher, K., & Dwyer, K. (2013). Conceptualizing and measuring collaboration in the context of early childhood care and education (OPRE Research Brief OPRE 2013-29). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US DHHS.

Chien, N., Daneri, P., Darling-Churchill, K., Goldhagen, S., Halle, T., Lippman, L., Moodie, S., & Zaslow, M. (May 2013). Characteristics of existing measures of social and emotional development in early childhood suitable for use in federal data collections. Paper prepared for project on Early Childhood Measures of Social and Emotional Development for Consideration by the Interagency Forum on Child and Family Statistics.

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Zaslow, M. & Tout, K. (October, 2014). Reviewing and clarifying goals, outcomes and levels of implementation: Toward the next generation of Quality Rating and Improvement Systems (QRIS). OPRE Research Brief #2014-75. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Brandon, R., Zaslow, M., Weber, R., Abe, Y., Milesi, C., Kim, H., Forry, N., Bautista, R., Datta, A.R., Goerge R., Gennetian, L., Witte, A., Guzman, L. & Zaoni, W. (October, 2015). Measuring predictors of quality in early care and education settings in the National

Survey of Early Care and Education (OPRE Report #2015-93). Washington, DC. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Epstein, D., Halle, T., Moodie, S., Sosinskyk, L, & Zaslow, M. (May, 2016). Examining the association between infant/toddler workforce preparation, program quality and child outcomes: A review of the research evidence (OPRE Report #2016-15). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Madill, R., Blasberg, A., Halle, T., Zaslow, M. & Epstein, D. (May, 2016). Describing the preparation and ongoing professional development of the infant/toddler workforce: An analysis of the National Survey of Early Care and Education data (OPRE Report #2016-16). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Workgroup on the Early Childhood Workforce and Professional Development (May, 2016). Proposed revisions to the definitions for the early childhood workforce in the Standard Occupational Classification: White paper commissioned by the Administration for Children and Families, U.S. Department of Health and Human Services (OPRE Report 2016-45). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Burchinal, M., Tarullo, L. & Zaslow, M. (July, 2016). Best practices in creating and adapting Quality Rating and Improvement System (QRIS) rating scales. OPRE Research Brief #2016-25. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Burchinal, M., Soliday Hong, S., Sabol, T., Forestieri, N., Peisner-Feinberg, E., Tarullo, L. and Zaslow, M. (July, 2016). Quality Rating and Improvement Systems: Secondary data analyses of psychometric properties of scale development. OPRE Report #2016-26. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Cohen, R. C., Zaslow, M, Raikes, H., Elicker, J., Paulsell, D., Dean, A., & Kreiner-Althen, K. (March, 2017). Working toward a definition of infant/toddler curricula: Intentionally furthering the development of individual children within responsive relationships. OPRE Report #2017-15. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US DHHS.

Zaslow, M. (December, 2017). A research perspective: Commentary in Tout, K., Magnuson, K., Lipscomb, S., Karoly, L., Starr, R., Quick, H…& Wenner, L. Validation studies of the quality ratings used in Quality Rating and Improvement Systems (QRIS): A synthesis of state studies. OPRE Report #2017-72. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US DHHS.

Zaslow, M. (2022). Early childhood education and care workforce development: A foundation for process quality, OECD Education Policy Perspectives, No. 54, OECD Publishing, Paris.

Zaslow, M., Halle, T., Madill, R., & Forry, N. (2024). *History of the National Survey of Early Care and Education, Part I: The Development of the 2012 NSECE.* OPRE Report #2024-009. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services

Zaslow, M., Halle, T., Madill, R., & Forry, N. (2024b). *History of the National Survey of Early Care and Education, Part II: The Development of the 2019 NSECE and the NSECE COVID-19 Longitudinal Follow-up.* OPRE Report #2024-010. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Edited Volumes

Zaslow, M. & Martinez-Beck, I., (Eds). (2006). *Critical issues in early childhood professional development.* Baltimore: Brookes Publishing.

Zaslow, M., Martinez-Beck, I., Tout, K., & Halle, T. (Eds.) (2011). *Quality measurement in early childhood settings.* Baltimore: Brookes Publishing.

Contributions as a Committee Member to Books and Federal Reports

Snow, C. & Van Hemel, S. (Eds.), Committee on Developmental Outcomes and Assessments for Young Children, National Research Council of the National Academies of Science (2008). *Early childhood assessment: Why, what and how.* Washington, DC: National Academies Press.

Advisory Committee on Head Start Research and Evaluation (August 2012). *Final report.* Submitted to the U.S. Department of Health and Human Services.

Compendia

Halle, T., Zaslow, M., Wessel, J., Moodie, S., & Darling-Churchill, K. (2011). Understanding and choosing assessments and developmental screeners for young children: Profiles of selected measures. Washington, D.C.: Office of Planning, Research and Evaluation, U.S. Department of Health and Human Services.

Madill, R., Moodie, S., Zaslow, M., & Tout, K. (2015). Review of selected studies and professional standards related to the predictors of quality included in the National Survey of Early Care and Education (OPRE Report #2015-93b). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services.

PRESENTATIONS (From 2010)

Zaslow, M. (May 2010). Introductory comments at congressional briefing on the report Healthy Development: A Summit on Young Children's Mental Health. Washington DC, Dirksen Senate Office Building.

Zaslow, M. (June 2010). Emerging conceptualizations of early childhood professional development. Presentation as part of panel on Increasing the Effectiveness of Training of Early Childhood Professionals, at Head Start's 10th National Research Conference, Washington, DC.

Zaslow, M. (June 2010). Chair, Panel on Mentoring and Coaching for Teachers in Head Start, at Head Start's 10th National Research Conference, Washington, DC.

Zaslow, M. (June 2010). Chair, panel on Recent Developments and Next Steps in the Measurement of Quality in Early Childhood Settings, at Head Start's 10th National Research Conference, Washington, DC.

Zaslow, M. (June 2010). Discussant at Poster Symposium on Recent Findings from the Early Head Start Evaluation: Contributions to Child Outcomes in 5th Grade, at Head Start's 10th National Research Conference, Washington, DC.

Halle, T., Zaslow, M., Wessel, J. Moodie, S., & Churchill, K.D. (June 2010). Improving the Selection of Child Outcome Screening and Assessment Instruments Used by Head Start Programs. Presentation as part of panel on Learning from Assessment: Improving the Use of Child Assessment Data in Early Childhood Programs, at Head Start's 10th National Research Conference, Washington, DC.

Zaslow, M. (August 2010). What do we know about practices that work for children's development? Presentation at Early Childhood 2010: Innovation for the Next Generation meeting co-sponsored by US Department of Health and Human Services and US Department of Education, Washington, DC.

Zaslow, M. (November 2010). Contrasting findings on early maternal employment and child outcomes. Discussant comments as part of panel on Employment Among Mothers of Infants at the fall research conference of the Association for Public Policy Analysis and Management, Boston, MA.

Zaslow, M. (November 2010). Emerging approaches for assessing the presence of thresholds of quality in early care and education. Discussants comments as part of panel on Ensuring Quality Investments in Early Childhood: Linking quality Measurement to Positive Child Outcomes at the fall research conference of the Association for Public Policy Analysis and Management, Boston MA.

Zaslow, M. (November 2010). Policy implications of recent research on effective professional development. Presentation at Leadership Symposium of the National Center for Research on Early Childhood Education on Effective Professional Development in Early Childhood Education, Arlington, VA.

Zaslow, M., Hutcheon, S., & Mandell, S. (February 2011). Fostering a bi-directional bridge between research and policy. Colloquium at George Mason University, Applied Developmental Psychology, Fairfax, VA.

Zaslow, M. (February 2011). Using data from early childhood assessments to strengthen children's school readiness. Presentation at National Head Start Summit, Baltimore, MD.

Zaslow, M., Tout, K., & Isner, T. (March 2011). On-site quality improvement approaches in early childhood settings. Plenary address at the BUILD conference, Arlington, VA.

Zaslow, M., Anderson, R., Wessel, J., Redd, Z., Tarullo, L., Burchinal, M. (March 2011). Building on previous literature in the study of quality dosage, thresholds and feature: The literature review within the Q-DOT project. Presentation at the biennial meeting of the Society for Research in Child Development, Montreal, Canada.

Zaslow, M. (April 2011). Challenges and opportunities in science policy: Perspectives from the Society for Research in Child Development. Invited presentation at the American Educational Research Association national conference, New Orleans, LA.

Zaslow, M. (April 2011). Emerging issues in early childhood professional development. Presentation at Secretary's Advisory Committee for Head Start Research, Arlington, VA.

Zaslow, M. (June 2011). Links among child care (quality stability and decision-making) and family economic well-being. Discussant's comments at the Welfare Research and Evaluation Conference, Washington, DC.

Zaslow, M. (June 2011). An overview of impacts on parenting and family outcomes in the Head Start and Early Head Start Impact Studies. Presentation at the Secretary's Advisory Committee for head Start Research, Washington, DC.

Forry, N., Tout, K., Zaslow, M., & Martinez-Beck, I. (June 2011). Seeking and benefitting from coaching and consultation: Results from recent research. Invited symposium at NAEYC's Professional Development Institute, Providence, RI.

Zaslow, M. (June 2011). Discussant's comments: Invited symposium on effective teaching in early care and education, NAEYC's Professional Development Institute, Providence, RI.

Zaslow, M. (October 2011). Recent developments in the research on coaching: Taking stock and identifying next steps. Invited presentation as part of panel on The Big Picture: Coaching, Mentoring and Systems Building at meeting on Working Together: Coaching and Mentoring in Early Childhood sponsored by the Administration for Children and Families, US Department of Health and Human Services, Washington, DC.

Zaslow, M. (November 2011). Building pathways and partnerships to support children's development: discussant's comments. Plenary at the meeting of the Child Care Policy Research Consortium, sponsored by the Office for Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services, held in Bethesda, MD.

Zaslow, M. (November 2011). Looking across the NAS Workshop on the Early Childhood Workforce and the National Survey for Early Care and Educations: Discussant's comments on implications for research. Presentation at the meeting of the Child Care Policy Research Consortium, sponsored by the Office for Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services, held in Bethesda, MD.

Zaslow, M. (June 2012). Society for Research in Child Development efforts to bridge research and policy. Presentation at the meeting of the National Association for the Education of Young Children Professional Development Institute, Indianapolis.

Zaslow, M. (June 2012). Themes from the Advisory Committee on Head Start Research and Evaluation. Presentation at Head Start's 11th National Research Conference, Washington, DC.

Zaslow, M. (June 2012). Discussant comments at panel on Linkages Between Quality and Child Outcomes: Deepening our Understanding at Head Start's 11th National Research Conference, Washington, DC.

Zaslow, M. (June 2012). Discussant comments at panel on Implementing Evidence-Based Coaching Models at Scale: Early Lessons from MyTeaching Partner at Head Start's 11th National Research Conference, Washington, DC.

Zaslow, M. (June 2012). Preconference session on Bridging Research and Policy at the National Research Conference on Child and Family Programs and Policy, Bridgewater State University, MA.

Zaslow, M. (July 2012). Issues to consider in working towards a common core of quality indicators for QRIS. Presentation at the Quality Initiatives Research and Evaluation Consortium Meeting, sponsored by the Office of Planning, Research and Evaluation, U.S. Department of Health and Human Services, Washington, D.C.

Zaslow, M. (October 2012). Suggested revisions to the definitions of occupations used in federal surveys to describe the early childhood workforce. Presented on behalf of the Steering Committee of the Workgroup on Early Childhood Professional Development and the Workforce, convened by the Office of Planning Research and Evaluation to follow up on the Workshop on the Early Childhood Workforce convened by the Board on Children, Youth and Families, National Academies of Science and Institute of Medicine. Briefing for Senior Staff of the Administration for Children and Families, US Department of Health and Human Services, Washington, DC.

Zaslow, M. (October 2012). Issues to consider in examining quality indicators in Quality Rating and Improvement Systems. Plenary presentation at the meeting of the Child Care Quality Policy Research Consortium, Washington, DC.

Zaslow, M., (November 2012). Purposeful early childhood assessment. Presentation for the Office of the Deputy Mayor for Education, Washington, DC.

Zaslow, M. (November 2013). Chair, panel on State longitudinal Educational Datasets at the annual Colloquium of the Consortium of Social Science Associations, Washington, DC.

Zaslow, M. (January 2013). Breaking into the "black box:" Measurement, workforce, interventions, and collaborations in the service of infants and toddlers. Meeting of the Network of Infant/Toddler Researchers, convened by the Office of Policy, Research and Evaluation, Administration for Children and Families, U.S., Department of Health and Human Services, Washington, DC.

Zaslow, M. (January 2013). Introductory comments at opening plenary of the meeting on International Children's Rights Frameworks and Research sponsored by the American Association for the Advancement of Science (AAAS) Science and Human Rights Coalition, Washington, DC.

Zaslow, M. (March 2013). Discussant comments for panel on Impacts and Implementation: Making the Transition from Research to Practice at Scale at meeting on Quality Improvement in Early Childhood Education, sponsored by the National Center for Research on Early Childhood Education, sponsored by the US Department of Education, Institute of Education Sciences, Washington, DC.

Zaslow, M. (April 2013). Panelist at Roundtable on Beyond a Sole Focus on Child Outcomes: Clarifying a Conceptual Framework for Early Care and Education Quality Improvement Initiatives at the Biennial Meeting of the Society for Research in Child Development, Seattle, Washington.

Zaslow, M. (April 2013). Chair of symposium on Focusing on the "R" in QRIS: Modeling State Rating Systems and Links to School Readiness at the Biennial Meeting of the Society for Research in Child Development, Seattle, Washington.

Zaslow, M. (April 2013). Discussant of panel on Testing for Thresholds in Associations Between Child Care Quality and Child Outcomes: Innovative Methodological Approaches at the Biennial Meeting of the Society for Research in Child Development, Seattle, Washington.

Zaslow, M. (April 2013). Chair of panel on Enhancing Diversity in Science: Working Together to Develop Common Data, Measures and Standards. Featured session on research and science policy at the Annual Meeting of the American Educational Research Association, San Francisco, California.

Zaslow, M. (April 2013). Panelist at session on Findings and Recommendations from the Advisory Committee on Head Start Research and Evaluation at the Second National Birth

to Five Leadership Institute, sponsored by the Office of Head Start, Administration for Children and Families, US Department of Health and Human Services, National Harbor, MD.

Zaslow, M. (June 2013). Summary Comments on Directions for PreK-3rd Evaluation and Research at meeting on Prek-3rd Research and Evaluation sponsored by the Foundation for Child Development, Washington, DC.

Zaslow, M. (July 2013). Discussant's Comments on Number and Characteristics of ECE Workers and Caregivers: Initial Findings from the National Survey of Early Care and Education at the meeting of the State and Territory Administrators Meeting (STAM), Washington, DC.

Zaslow, M., & Tout, K. (August 2013). QRIS: A Framework for Quality Improvement in Support of Multiple Outcomes. Plenary Presentation at the 2013 BUILD Initiative QRIS National Learning Network Meeting, August 1, 2013, Washington, DC.

Zaslow, M. (November 2013). Discussant comments at meeting on The Role of Instability in Children's Success: A Dialogue Across Research, Policy and Practice, The Urban Institute, Washington, DC

Zaslow, M. (January 2014). Thinking about QRIS. Presentation at the 26th Annual Meeting of national and State Child Care Advocates, Baltimore, MD.

Zaslow, M. & Forry, N. (January 2014). Update from the National Survey of Early Care and Education. Presentation at the meeting of the Network of Infant/Toddler Researchers Third Annual meeting, Washington, DC.

Zaslow, M. (January 2014). Overcoming Key Issues and Challenges in Dissemination, Translation and Outreach. Keynote Speaker at Science of Learning Symposium and Symposium on Excellence in Teaching and Learning in the Sciences, Johns Hopkins University, Baltimore, MD.

Zaslow, M. (April 2014). Chair, Session on Linking Early Childhood Research with Policy, Child Care Aware National Symposium, Washington, DC.

Zaslow, M. (June 2014). The Evidence on Preschool Education. Presentation at the Meeting of the Coalition for Psychology in Schools and Education, American Psychological Association, Washington, DC.

Zaslow, M. (June 2014). Summary Comments at meeting on Transitions, Continuity and Alignment from Preschool to Third Grade, sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services, Washington, DC.

Zaslow, M. (July 2014). Discussant's Comments, Opening Plenary at Head Start's 12th National Research Conference, Washington, DC.

Zaslow, M. (July 2014). Discussant's Comments, Panel on A National Picture of Participation in Professional Development by the Early Childhood Workforce: Matches and Mismatches with the Research on Effective Professional Development Approaches. Head Start's 12th National Research Conference, Washington, DC.

Zaslow, M. (October 2014). New findings on professional development from the National Survey of Early Care and Education. Meeting of the National Workforce Registry Alliance, Columbus, Ohio.

Zaslow, M, Tarullo, L., & Burchinal, M. (November 2014). Thresholds of quality in early care and education. Colloquium at University for Maryland Center for Children, Relationships and Culture, College Park, MD.

Zaslow, M. (November 2014). Early care and education in the United States: Selected findings from the National Survey of Early Care and Education. Presentation at the meeting of the Child Care Policy Research Consortium, Washington, DC.

Zaslow, M. & Martinez-Beck, I. (November 2014). Suggested revisions to the definitions of occupations used in federal surveys to describe the early childhood workforce. Presentation at the meeting of the Child Care Policy Research Consortium, Washington, DC.

Zaslow, M. (March 2015). Moderator, SRCD Policy Fellowship panel at the Biennial Meeting of the Society for Research in Child Development, Philadelphia, PA.

Zaslow, M. (March 2015). Expectations about children's outcomes in Quality Rating and Improvement Systems: Perspectives on an expanded conceptual framework. Roundtable at the Biennial Meeting of the Society for Research in Child Development, Philadelphia, PA.

Zaslow, M. (December 2015). Presentation as part of panel on "What does curriculum mean in the context of working with infants and toddlers and how do we verify implementation?" at the meeting of the Child Care Policy Research Consortium, Washington, DC.

Zaslow, M. (December 2015). Presentation as part of panel on "State and national data on the early childhood workforce: Comparing state workforce registries with findings from the National Survey of Early Care and Education" at the meeting of the meeting of the Child Care Policy Research Consortium, Washington, DC.

Zaslow, M. (December 2015). Presentation as part of concluding plenary on "The Child Care Policy Research Consortium: Looking forward" at the meeting of the Child Care Policy Research Consortium, Washington, DC.

Zaslow, M. (February 2016). Presentation as part of webinar for the Promise Zones Early Childhood Peer Learning and Action Network: Building an Early Childhood Workforce to Support Quality.

Zaslow, M. (January 2017). Quality thresholds, features and dosage in early care and education: Initial exploration and implications. Guest lecture as part of the Virginia Education Sciences Training Program supported by the U.S. Department of Education, Institute of Education Sciences at the University of Virginia Curry School of Education.

Zaslow, M. (March 2017). Presentation as part of panel: Implications of new research and policy for Quality Rating and Improvement Systems (QRIS) design, implementation and evaluation. Meeting of the Child Care Policy Research Consortium sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services, Washington, DC.

Zaslow, M. (March 2017). Discussant comments as part of Plenary: Research-to-policy translation for generating evidence-based child care and early education policy. Meeting of the Child Care Policy Research Consortium, Office of Planning Research and Evaluation, Administration for Children and Families, US Department of Health and Human Services, Washington, DC.

Zaslow, M. (March 2017). SRCD's role in bridging research and policy. Colloquium in the Department of Applied Developmental Psychology, George Mason University.

Zaslow, M. (March 2018). Bridging research and policy on children's development. Colloquium in the Department of Human Development and Quantitative Methodology, University of Maryland.

Zaslow. M. (March 2019). Panelist: From dissertation to day Job: Pre-doctoral, early, mid and advanced career fellowships and funding opportunities. Panel at Biennial Meeting of the Society for Research in Child Development, Baltimore, MD.

Zaslow, M. (March 2019). Moderator, SRCD Policy Fellowship panel and reception. Biennial Meeting of the Society for Research in Child Development, Baltimore, MD.

Zaslow, M. (March 2019). Panelist on Access to early care and education. Roundtable at the Biennial Meeting of the Society for Research in Child Development, Baltimore, MD.

Zaslow, M. (March 2019). Participant as a leader at Lunch with the Leaders mentoring session. Biennial Meeting of the Society for Research in Child Development, Baltimore, MD.

Lombardi, C. M., Chazan-Cohen, R., & Zaslow, M. (June 2022). Unpacking comprehensive services in Early Head Start. Paper presented at the National Research Conference on Early Childhood, virtual.

Lombardi, C. M., Chazan Cohen, R., & Zaslow, M. (November 2022). Understanding comprehensive services in Early Head Start for children and families with greater needs. Paper presented at the annual meeting of the Association for Public Policy Analysis and Management, Washington, DC.

Lombardi, C. M., Chazan Cohen, R., & Zaslow, M. (March 2023). Understanding comprehensive service referrals among families in Early Head Start. Paper presented at the biennial meeting of the Society for Research in Child Development, Salt Lake City, UT.

Zaslow, M. (May 2023). Research on the use of evidence in policy and practice. Presentation prepared for the Convening of the Foundation for Child Development Young Scholars Program, Washington, DC.