**Child Information – General**

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| First Name: | Middle Initial: | Last Name: | Preferred Name: |
| Date of Birth (month/day/year): | | Gender:  M  F | |

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| What is this child’s home language? | | | 2nd language: | |
| This child speaks: | Only English | Mostly English and another language | | \*Some English, but mostly another language |
| Both English and another language the same (bilingual) | | | \*Only a language other than English |

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| Is this child Hispanic/Latino?  Yes  No | |
| What is this child’s race? Check all that apply. | |
| African/African American/Black  Asian  Alaska Native/Native American/American Indian | Native Hawaiian or Pacific Islander  White  Not listed above: |
| What is your family’s heritage/tribe/country of origin? | |
| Is this child part of a tribe either by membership or by ancestry/lineage?  Yes  No | |

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| Has this child been previously enrolled in these programs? Only check the **most recent**. | | | |
| None  Early Support for Infants and Toddlers (ESIT), IDEA Part C, ECLIPSE or any Birth-to-Three/Home Visiting program | Head Start/Early Head Start/ECEAP/Early ECEAP in King or Pierce County, Washington State  Head Start/Early Head Start/ECEAP /Early ECEAP in another Washington State County | | Migrant/Seasonal Head Start anywhere in Washington State |
| When did this child last attend? | | Name and location of program: | |
| Is this child currently enrolled in a community slot at this site?  Yes  No | | | |
| Is this child a **sibling** of a child currently enrolled in the program you are applying to?  Yes  No | | | |

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| **The questions below are for information only. Answering “Yes” will not affect your eligibility or enrollment in the program.** | | |
| Is this child in official foster care or kinship care **with** a grant amount?  Yes  No | | |
| **If yes,** what is the Case Number or Client ID Number? | | |
| What is the monthly grant/payment amount and source? **$**  # of children covered by grant amount: | | DSHS  SSI  Tribe  Other |
| Is this child in kinship care **without** a grant amount?  Yes  No | | |
| Was this child adopted after foster care or kinship care or from orphanage from another country?  Yes  No | | |
| Was this child recently reunited with their parent(s) after foster care or kinship care?  Yes  No | | |
| Does your family currently receive services /support through Child Protective Services (CPS), Family Assessment Response (FAR), Indian Child Welfare (ICW), comparable tribal services, or law enforcement/court system?  Yes  No | | |
| Has your family received services/support from CPS/FAR/ICW, comparable tribal services, or law enforcement/court system in the past?  Yes  No | | |
| Is your family currently approved for childcare through CPS or FAR? | | |
| Yes – How many approved hours per week? | No | |
| Has this child ever been asked to leave an early learning program because of behavior issues?  Yes  No | | |

**Child Information – Health**

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| Does this child have medical insurance?  Yes  No | | | | | | |
| **If yes**, what type? | | Washington Apple Health/ProviderOne | Private Insurance | | Tribal | Military Medical Coverage |
| Does this child have a regular doctor or medical clinic? | | | | | | |
| Yes - Name of clinic/provider: | | | | Name of medical professional: | | |
| No | | | | | | |
| Did this child have a well-child exam within the last 12 months? | | | | | | |
| Yes – Date of last exam (month/day/year): | | | | | | |
| No | Date Unknown | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Does this child have dental insurance?  Yes  No | | | | | | | |
| **If yes,** what type? | | Washington Apple Health/ProviderOne | Private Insurance | | Tribal | ABCD | Military Dental Coverage |
| Does this child have a regular dentist or dental clinic? | | | | | | | |
| Yes - Name of clinic/provider: | | | | Name of dental professional: | | | |
| No | | | | | | | |
| Did this child have dental exam within the last 6 months? | | | | | | | |
| Yes – Date of last exam (month/day/year): | | | | | | | |
| No | Date Unknown | | | | | | |

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| What is your child’s immunization status?  Fully immunized  Exempt  Not fully immunized or exempt  Not sure |

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| Does this child have a chronic health condition (may include mental health, asthma, cancer, diabetes, seizures, ADHD, autism, spina bifida, sickle cell disease, or life-threatening allergies)? | |
| Yes – Please describe: | The health condition is considered:  Severe  Moderate  Mild |
| No Has a Health Care Provider diagnosed this condition?  Yes  No | |

**Child Information - Development**

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| Do you have concerns about this child’s health?  Yes – check all that apply below  No | | |
| Low birth weight (less than 5.5 lbs/5 lbs 8 oz.)  Hearing | Preterm birth less than 37 weeks  Fine motor/gross motor | Drug/alcohol affected  Tooth pain/decay/bleeding gums |
| Vision | Food intolerance/special diet –  Please describe: | |

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| Does this child have a **current and active** Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?  Yes – Please provide a copy with your application. |
| No – Check if any of these apply: |
| My child has a diagnosed developmental delay or disability, has no IEP, **or** is being referred for evaluation.  My child has a suspected developmental delay or disability. |

**Parent/Guardian Information**

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| This child lives with: |
| One parent/guardian **(complete Parent/Guardian 1)** |
| Two parents/guardians in the same household **(complete Parent/Guardian 1 & 2)** |
| Two parents/guardians in two households **(complete Parent/Guardian 1 & 2)** |

|  | **Parent/Guardian 1** | | | **Parent/Guardian 2** | | |
| --- | --- | --- | --- | --- | --- | --- |
| Name |  | | |  | | |
| Relationship to child | Biological/Adopted/Stepparent | | | Biological/Adopted/Stepparent | | |
| Foster Parent  Grandparent | Aunt/Uncle  Other: | | Foster Parent  Grandparent | Aunt/Uncle  Other: | |
| Gender | M  F  Not specified | | | M  F  Not specified | | |
| Date of Birth (month/day/year) |  | | |  | | |
| Address (include City, State, Zip) |  | | |  | | |
| Phone |  | | Home  Cell  Work |  | | Home  Cell  Work |
| Alternate Phone |  | | Home  Cell  Work |  | | Home  Cell  Work |
| Email |  | | |  | | |
| Were you under age 18 when this child was born? | Yes  No  N/A | | | Yes  No  N/A | | |
| What language(s) do you speak? |  | | |  | | |
| Do you need an interpreter for this language? | Yes  No | | | Yes  No | | |
| What is your race? Check all that apply | African/African American/Black  Asian  Alaska Native/Native American/American Indian  Native Hawaiian or Pacific Islander  White  Not listed above: | | | African/African American/Black  Asian  Alaska Native/Native American/American Indian  Native Hawaiian or Pacific Islander  White  Not listed above: | | |
| What is the **highest** level of education you completed? | 6th grade or less  7th to 12th grade, no diploma or GED  High school diploma  GED  Some college/advanced training  College/professional certificate  Associate degree  Bachelor’s degree  Master’s or doctorate degree  None | | | 6th grade or less  7th to 12th grade, no diploma or GED  High school diploma  GED  Some college/advanced training  College/professional certificate  Associate degree  Bachelor’s degree  Master’s or doctorate degree  None | | |

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|  | **Parent/Guardian 1** | **Parent/Guardian 2** |
| Are you currently employed? | Yes – How many hours per week (including travel)?    Employer name & phone #:    No  No, retired or disabled  Seasonal | Yes – How many hours per week (including travel)?    Employer name & phone #:    No  No, retired or disabled  Seasonal |
| Are you currently in job training or school? | Yes – How many hours per week (including class  time, study time, travel)?    School name & major/goal:    No | Yes – How many hours per week (including class  time, study time, travel)?    School name & major/goal:    No |
| Are you in an approved WorkFirst activity? | Yes – Describe the activity and the number of approved hours per week:  No | Yes – Describe the activity and the number of approved hours per week:  No |
| Are you or have been in the U.S. military? | Yes, current service member  Yes, currently deployed or have been in the last 12 months/for a total of 19 months  Yes, veteran  No | Yes, current service member  Yes, currently deployed or have been in the last 12 months/for a total of 19 months  Yes, veteran  No |

**Family Concerns**

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| Please check areas of concern that you have for yourself/family in your household. | | |
| Household member has a disability **or** has a chronic physical or mental health condition **and** is:  Unable to engage in work/school/family life  Somewhat able to engage in work/school/ family life  Mostly able to engage in work/school/family life  Child’s parent/guardian has learning difficulties, no disability  Household domestic violence (past or current), including *in utero*  Household drug/alcohol issues or substance abuse (past or current), including *in utero* | Family is socially isolated, with complete or near-complete lack of contact with others  Child’s parent/guardian concern for getting or keeping a job  Family has legal concerns  Child has a family member who attended Indian Boarding School  Child’s parent/guardian is a migrant or seasonal worker with more than half of family income coming from agricultural work  Parent and child moved to engage in traditional cultural practices or employment (seasonal or temporary in agricultural or fishing) | Recent immigrant/refugee (past 5 years)  Child’s parent/guardian is incarcerated  Loss of a parent (death, abandonment, or deportation)  Child’s parents/guardians divorced or separated during child’s life  Family previously homeless (in the last 12 months)  Family concerns with housing |

**Family Living Situation**

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| Does this household receive subsidized housing such as a housing voucher or cash assistance for housing?  Yes  No |

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| What is your family’s current housing situation? **The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. Your answers may help us determine the services your child may be eligible to receive.** | |
| Own  Rent | In someone else’s house or apartment with another family:   * By choice (e.g., to share responsibilities, to be close to family, etc.) |
| In a motel  In a shelter  A car, park, campsite, or similar location | * Due to loss of housing, economic hardship, or similar reason   Transitional Housing  Moving from place to place/couch surfing  In a residence with inadequate facilities (no water, heat, electricity) |
| Other – Please describe: | |

**Family Income and Family Size**

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| Check all that apply if you, this child, or another person living in your home related to you by blood, marriage, or adoption receive these types of Public Assistance.  SSI for disability received by:  Child  Parent/Guardian  Other – Relationship to child:  Temporary Assistance for Needy Families (TANF) cash  SNAP |
| Check all that apply if your family receives the following:  Child-only TANF  WorkFirst  Working Connections Child Care subsidy  WIC |

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| Were you referred to this program by an agency?  Yes - Name: | No |

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| **Please list additional people living in this child’s primary household below, not including yourself or this child.** | | | | |
| Name (First and Last) | Birthdate (month/day/year) | Relationship to child | Do you financially support this person? | Is this person related to you by blood, marriage, or adoption? |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |
|  |  |  | Yes  No | Yes  No |

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| What is the **total number** of family members living in your home, including yourself and this child? |
| What is your **total estimated** household income for the last calendar year or the last 12 months? |

I promise that the information on this form is true and correct. I have reported all my income and family size, as required by the Early Learning Programs. If I knowingly provide false information, I understand my family may be unable to continue program services. Additionally, if my child is enrolled in ECEAP, I may have to repay the amount spent on my child.

I understand that information from this application is entered in various Early Learning databases operated by the Department of Children, Youth, and Families (DCYF) and Puget Sound Educational Service District (PSESD). DCYF and PSESD are committed to protecting confidential and personal information that could identify a child or family. No information related to immigration status is entered in the databases or shared with state or federal agencies. Information in the databases may be used for the following:

* Research studies to determine if participating in Early Learning helps children later in life.
* To prove Washington State spends some of their own dollars on programs for families, which is required to receive Temporary Assistance for Needy Families dollars from the federal government.

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**(ECEAP Staff: Enter this date in ELMS)**

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| **\*Staff Only – If not signed, complete below. Parent signature must be obtained as soon as possible, or no later than the enrollment visit.** | |
| **Reviewed and received verbal verification on (date):** | **Staff Initials:** |
| (ECEAP Staff: Enter this date in ELMS if not signed – you cannot update this once the ELMS application is locked) | |

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| **PSESD Early Learning Staff Only** | | | | | | | |
| **Section 1:** Staff who finalize and determine eligibility complete this section before placing in the Master Waitlist Drawer | | | | | | | |
| Child’s Age: | Total Verified Family Size: | | | Total Verified Income: | | | Total Points: |
| Site Name/ID: | | | | Date received:  (This date will determine eligibility timeframe) | | | |
| Date staff reviewed application with family: | | | | Date sent to PSESD (N/A for ECEAP only sites): | | | |
| **EHS Only** - Is this child a newborn taking the family’s slot?  Yes  No | | | If yes, family’s name: | | | | |
| **Section 2:** For McKinney-Vento Act children/families. Check services the family received. Staff should provide resources within 24-48 hours. | | | | | | | |
| Childcare resources  Clothing resources  School supplies  Medical/dental referral  Housing/shelter referral | | Immunization/medical records  Vision referral  Hygiene products/toiletries  Food resources  Birth certificate | | | Medicaid/DSHS services – Food stamps/TANF | | |
| College/vocational/technical resources | | |
| School transportation (if site provides) | | |
| Other: | | |
|  | | |
| **Staff Name & Signature:** | | | | | | **Date:** | |