**Child Information – General**

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| First Name: Click or tap here to enter text. | Middle Initial: Click or tap here to enter text. | Last Name: Click or tap here to enter text. |
| Date of Birth (month/day/year): Click or tap here to enter text. | | Gender: M F |

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| What is this child’s home language? Click or tap here to enter text. | | | 2nd language: Click or tap here to enter text. | |
| Does this child speak: | 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: Click or tap here to enter text. |
| What is your family’s heritage/tribe/country of origin? Click or tap here to enter text. | |

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| Has this child previously attended these programs? Only check the **most recent**: | | | |
| None  Early Support for Infants and Toddlers (ESIT) or any Birth-to-Three/Home Visiting program | Head Start/Early Head Start/ECEAP in King or Pierce County, Washington State  Head Start/Early Head Start/ECEAP in another Washington State County | | Migrant/Seasonal Head Start anywhere in Washington State |
| When did this child last attend? Click or tap here to enter text. | | Name and location of program: Click or tap here to enter text. | |
| Is this child currently enrolled in a community slot at this site? Yes No | | | |
| Is this child a **sibling** of a currently enrolled child at this site? 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? Click or tap here to enter text. | |
| What is the monthly grant/payment amount and source? **$** Click or tap here to enter text.  # of children covered by grant amount: Click or tap here to enter text. | 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? Yes No | |
| Does your family currently receive services through Child Protective Services (CPS), Family Assessment Response (FAR), or Indian Child Welfare (ICW)? Yes No | |
| Has your family received services from CPS/FAR/ICW in the past? Yes No | |
| Is your family currently approved for child care through CPS or FAR?  Yes – How many approved hours per week? Click or tap here to enter text.  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: Click or tap here to enter text. | | | | Name of medical professional: Click or tap here to enter text. | | |
| No | | | | | | |
| Did this child have a well-child exam within the last 12 months? | | | | | | |
| Yes – Date of last exam (month/day/year): Click or tap to enter a date. | | | | | | |
| No | Date Unknown | | | | | |
| 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 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: Click or tap here to enter text. | | | | Name of dental professional: Click or tap here to enter text. | | | |
| No | | | | | | | |
| Did this child have dental exam within the last 6 months? | | | | | | | |
| Yes – Date of last exam (month/day/year): Click or tap to enter a date. | | | | | | | |
| No | Date Unknown | | | | | | |

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| Has this child been diagnosed by a Health Care Provider with a chronic health condition (may include asthma, cancer, diabetes, seizures, ADHD, autism, spina bifida, sickle cell disease, or life-threatening allergies)? | |
| Yes – Please describe: Click or tap here to enter text. | The health condition is considered: Severe Moderate Mild |
| 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: Click or tap here to enter text. | |

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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 | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
| Relationship to child | Biological/Adopted/Stepparent | | | Biological/Adopted/Stepparent | | |
| Foster Parent  Grandparent | Aunt/Uncle  Other: Click or tap here to enter text. | | Foster Parent  Grandparent | Aunt/Uncle  Other: Click or tap here to enter text. | |
| Gender | M F Not specified | | | M F Not specified | | |
| Date of Birth (month/day/year) | Click or tap to enter a date. | | | Click or tap to enter a date. | | |
| Address | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
| Phone | Click or tap here to enter text. | | Home Cell Work | Click or tap here to enter text. | | Home Cell Work |
| Alternate Phone | Click or tap here to enter text. | | Home Cell Work | Click or tap here to enter text. | | Home Cell Work |
| Email | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
| Were you under age 18 when this child was born? | Yes No N/A | | | Yes No N/A | | |
| What language(s) do you speak? | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
| 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: Click or tap here to enter text. | | | African/African American/Black  Asian  Alaska Native/Native American/American Indian  Native Hawaiian or Pacific Islander  White  Not listed above: Click or tap here to enter text. | | |
| 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)?  Click or tap here to enter text.  Employer name & phone #:  Click or tap here to enter text.  No  No, retired or disabled  Seasonal | Yes – How many hours per week (including travel)?  Click or tap here to enter text.  Employer name & phone #:  Click or tap here to enter text.  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)?  Click or tap here to enter text.  School name & major/goal:  Click or tap here to enter text.  No | Yes – How many hours per week (including class  time, study time, travel)?  Click or tap here to enter text.  School name & major/goal:  Click or tap here to enter text.  No |
| Are you in an approved WorkFirst activity? | Yes – Describe the activity and the number of approved hours per week: Click or tap here to enter text.  No | Yes – Describe the activity and the number of approved hours per week: Click or tap here to enter text.  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: | | |
| Child’s parent/guardian has a disability or is chronically ill 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 mental illness, including maternal depression (child is diagnosed, or adult is experiencing)  Household domestic violence (past or current)  Household drug/alcohol issues or substance abuse (past or current)  Family is socially isolated, with complete or near-complete lack of contact with others  Getting or keeping a job | Legal concerns  Child’s parent/guardian is a migrant worker  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  Previously homeless (in the last 12 months)  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 | | | |
| 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.** | | | |
| Rent  Own | In a motel  In a shelter | A car, park, campsite, or similar location  Transitional Housing | Moving from place to place/couch surfing  In a residence with inadequate facilities (no water, heat, electricity) |
| In someone else’s house or apartment with another family:   * By choice (e.g. to save money, to be close to family, etc.) * Due to loss of housing, economic hardship, or similar reason | | | Other – Please describe: Click or tap here to enter text. |

**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: Click or tap here to enter text.  Temporary Assistance for Needy Families (TANF) cash. |
| Check if you also have the following: Child-only TANF WorkFirst Working Connections Child Care subsidy |

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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? |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Yes No | Yes No |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | 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? Click or tap here to enter text. |
| What is your **total estimated** household income for the last calendar year or the last 12 months? Click or tap here to enter text. |

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):** Click or tap here to enter text. | **Staff Initials:** Click or tap here to enter text. |
| (ECEAP Staff: Enter this date in ELMS if not signed – you cannot update this once the ELMS application is locked) | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Staff Only** | | | | | | | |
| **Child’s Age:** Click or tap here to enter text. | **Total Verified Family Size:** Click or tap here to enter text. | | **Total Verified Income:** Click or tap here to enter text. | | | | **Total Points:** Click or tap here to enter text. |
| **Site Name/ID:** Click or tap here to enter text. | | | | **Date received:** Click or tap here to enter text.  (This date will determine eligibility timeframe) | | | |
| **Date staff reviewed application with family:** Click or tap here to enter text. | | | | **Date sent to PSESD (N/A for ECEAP only sites):** Click or tap here to enter text. | | | |
| **EHS Only - Is this child a newborn taking the mother’s slot? Yes No** | | | **If yes, mother’s name:** Click or tap here to enter text. | | | | |
| **For Homeless Families – Check the services that are needed or desired by the family and provide resources as soon as possible:** | | | | | | | |
| Child care 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: Click or tap here to enter text. | |
|  | |
| **Staff Name & Signature:** Click or tap here to enter text. | | | | | **Date:** Click or tap here to enter text. | | |