

Child Information – General

First Name:	Middle Initial:	Last Name:
Date of Birth (month/day/year):	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
What is your child's home language?	2 nd language:	
Is your child Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your child's race? Check all that apply:		
<input type="checkbox"/> African/African American/Black	<input type="checkbox"/> Native Hawaiian or Pacific Islander	
<input type="checkbox"/> Asian	<input type="checkbox"/> White	
<input type="checkbox"/> Alaska Native/Native American/American Indian	<input type="checkbox"/> Not listed above: _____	
What is your family's heritage/tribe/country of origin?		
Has your child previously attended these programs? Only check the most recent :		
<input type="checkbox"/> None	<input type="checkbox"/> Head Start/Early Head Start/ECEAP at this center	<input type="checkbox"/> Migrant/Seasonal Head Start anywhere in Washington State
<input type="checkbox"/> Any Birth-to-Three Home Visiting Program	<input type="checkbox"/> Head Start/Early Head Start/ECEAP at another center	
<input type="checkbox"/> Early Support for Infants and Toddlers (ESIT)		
When did you last attend? _____	Name and location of program: _____	
Is this child currently enrolled in a community slot at this center? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this child's sibling currently enrolled in a community slot at this center? <input type="checkbox"/> Yes <input type="checkbox"/> No		
The questions below are for information only. Answering "Yes" will not affect your eligibility or enrollment in the program.		
Is your child in official foster care or kinship care with a grant amount?		
<input type="checkbox"/> Yes - Case # or Client ID # _____	<input type="checkbox"/> No	
Monthly grant/payment amount and source _____	<input type="checkbox"/> DSHS <input type="checkbox"/> SSI <input type="checkbox"/> Tribe <input type="checkbox"/> Other	
# of children covered by grant amount _____		
Is your child in kinship care without a grant amount? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was your child adopted after foster care or kinship care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your child ever been asked to leave a childcare center or preschool because of behavior issues? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your family currently receive services through the following?		
<input type="checkbox"/> Child Protective Services (CPS) <input type="checkbox"/> Family Assessment Response (FAR) <input type="checkbox"/> Indian Child Welfare (ICW)? <input type="checkbox"/> None		
Has your family received services from CPS or ICW in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is your family currently approved for child care through CPS or FAR? <input type="checkbox"/> Yes – How many approved hours per week? _____ <input type="checkbox"/> No		

Child Health and Development Information

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

Early Learning Application 2019-2020

Child Health and Development Information continued

Did this child have a dental exam within the last 6 months?		<input type="checkbox"/> Yes – Date of last exam (month/day/year): _____	<input type="checkbox"/> No	<input type="checkbox"/> Date Unknown
Has your child been diagnosed by a Health Care Provider with one or more serious/chronic health conditions, such as asthma, diabetes, seizures, heart condition, or life-threatening allergies?				
<input type="checkbox"/> Yes – Please describe: _____		<input type="checkbox"/> No		
What is your child's immunization status? <input type="checkbox"/> Fully immunized <input type="checkbox"/> Exempt <input type="checkbox"/> Not fully immunized or exempt				
Do you have concerns about your child's health? <input type="checkbox"/> Yes – check all that apply below <input type="checkbox"/> No				
<input type="checkbox"/> Low birth weight (less than 5.5 lbs/5 lbs 8 oz.)	<input type="checkbox"/> Drug/alcohol affected			
<input type="checkbox"/> Hearing	<input type="checkbox"/> Fine motor/gross motor			
<input type="checkbox"/> Vision	<input type="checkbox"/> Mental health – Describe: _____			
<input type="checkbox"/> Tooth pain/decay/bleeding gums	<input type="checkbox"/> Food intolerance/special diet – Describe: _____			
Does your child have a current Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, check all the categories of the IEP/IFSP and include a copy with your application:				
<input type="checkbox"/> Autism	<input type="checkbox"/> Intellectual disability	<input type="checkbox"/> Specific learning disability		
<input type="checkbox"/> Deaf-blindness	<input type="checkbox"/> Multiple disabilities	<input type="checkbox"/> Speech/language impairment		
<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Orthopedic impairment	<input type="checkbox"/> Traumatic brain injury		
<input type="checkbox"/> Emotional disturbance	<input type="checkbox"/> Other health impairment	<input type="checkbox"/> Visual impairment		
<input type="checkbox"/> Hearing impairment				
IEP start date: _____		IEP end date: _____		What school district issued the IEP? _____
Is Special Ed Preschool or Birth-to-Three Program available/easily accessible to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know				
If no, do you suspect that your child has a developmental delay or disability?				
<input type="checkbox"/> Yes – <input type="checkbox"/> Speech/language		<input type="checkbox"/> No		
<input type="checkbox"/> Behavior – Describe: _____				
<input type="checkbox"/> Other – Describe: _____				

Family Information

	Parent/Guardian 1	Parent/Guardian 2
Name:		
Relationship to child	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____
Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Not specified	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Not specified
Date of Birth (month/day/year)		
Address		
Phone	_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Alternate Phone	_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Email		
Were you under age 18 when this child was born?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Do you need an interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language(s) do you speak? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language(s) do you speak? _____



Early Learning Application 2019-2020

Family Information continued

	Parent/Guardian 1	Parent/Guardian 2												
What is the highest level of education you completed?	<input type="checkbox"/> 6 th grade or less <input type="checkbox"/> 7 th to 12 th grade, no diploma or GED <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's or doctorate degree <input type="checkbox"/> None	<input type="checkbox"/> 6 th grade or less <input type="checkbox"/> 7 th to 12 th grade, no diploma or GED <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's or doctorate degree <input type="checkbox"/> None												
Are you currently employed?	<input type="checkbox"/> Yes – How many hours per week (including travel)? _____ Employer name & phone # _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal	<input type="checkbox"/> Yes – How many hours per week (including travel)? _____ Employer name & phone # _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal												
Are you currently in job training or school?	<input type="checkbox"/> Yes – How many hours per week (including class time, study time, travel)? _____ School name & major/goal _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes – How many hours per week (including class time, study time, travel)? _____ School name & major/goal _____ <input type="checkbox"/> No												
Are you in an approved WorkFirst activity?	<input type="checkbox"/> Yes – Describe the activity and the number of approved hours per week: _____ _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes – Describe the activity and the number of approved hours per week: _____ _____ <input type="checkbox"/> No												
Are you on active U.S. military duty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Are you a member of a National Guard or Military Reserve unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Are you a U.S. military veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Please check areas of concern that you have for yourself/family in your household: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Previously homeless (in the last 12 months)</td> <td><input type="checkbox"/> Household mental illness/counseling, including maternal depression</td> <td><input type="checkbox"/> Household drug/alcohol issues or substance abuse</td> </tr> <tr> <td><input type="checkbox"/> Child's parent/guardian is disabled</td> <td><input type="checkbox"/> Child's parent/guardian is a migrant worker</td> <td><input type="checkbox"/> Family is socially isolated, with complete or near-complete lack of contact with others</td> </tr> <tr> <td><input type="checkbox"/> Child's parent/guardian is currently/recently deployed to a combat zone</td> <td><input type="checkbox"/> Household domestic violence (past or current)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Child's parent/guardian is incarcerated</td> <td></td> <td></td> </tr> </table>			<input type="checkbox"/> Previously homeless (in the last 12 months)	<input type="checkbox"/> Household mental illness/counseling, including maternal depression	<input type="checkbox"/> Household drug/alcohol issues or substance abuse	<input type="checkbox"/> Child's parent/guardian is disabled	<input type="checkbox"/> Child's parent/guardian is a migrant worker	<input type="checkbox"/> Family is socially isolated, with complete or near-complete lack of contact with others	<input type="checkbox"/> Child's parent/guardian is currently/recently deployed to a combat zone	<input type="checkbox"/> Household domestic violence (past or current)		<input type="checkbox"/> Child's parent/guardian is incarcerated		
<input type="checkbox"/> Previously homeless (in the last 12 months)	<input type="checkbox"/> Household mental illness/counseling, including maternal depression	<input type="checkbox"/> Household drug/alcohol issues or substance abuse												
<input type="checkbox"/> Child's parent/guardian is disabled	<input type="checkbox"/> Child's parent/guardian is a migrant worker	<input type="checkbox"/> Family is socially isolated, with complete or near-complete lack of contact with others												
<input type="checkbox"/> Child's parent/guardian is currently/recently deployed to a combat zone	<input type="checkbox"/> Household domestic violence (past or current)													
<input type="checkbox"/> Child's parent/guardian is incarcerated														
<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Other household members have no medical/dental insurance</td> <td><input type="checkbox"/> Child's parent/guardian has health concerns</td> <td><input type="checkbox"/> Getting or keeping a job</td> </tr> <tr> <td><input type="checkbox"/> Other household members have no medical/dental home</td> <td><input type="checkbox"/> Child's parent/guardian has learning difficulties</td> <td><input type="checkbox"/> Legal concerns</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Concerns with housing</td> <td><input type="checkbox"/> Recent immigrant/refugee (past 5 years)</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Recently deceased family member</td> </tr> </table>			<input type="checkbox"/> Other household members have no medical/dental insurance	<input type="checkbox"/> Child's parent/guardian has health concerns	<input type="checkbox"/> Getting or keeping a job	<input type="checkbox"/> Other household members have no medical/dental home	<input type="checkbox"/> Child's parent/guardian has learning difficulties	<input type="checkbox"/> Legal concerns		<input type="checkbox"/> Concerns with housing	<input type="checkbox"/> Recent immigrant/refugee (past 5 years)			<input type="checkbox"/> Recently deceased family member
<input type="checkbox"/> Other household members have no medical/dental insurance	<input type="checkbox"/> Child's parent/guardian has health concerns	<input type="checkbox"/> Getting or keeping a job												
<input type="checkbox"/> Other household members have no medical/dental home	<input type="checkbox"/> Child's parent/guardian has learning difficulties	<input type="checkbox"/> Legal concerns												
	<input type="checkbox"/> Concerns with housing	<input type="checkbox"/> Recent immigrant/refugee (past 5 years)												
		<input type="checkbox"/> Recently deceased family member												

Early Learning Application 2019-2020

Family Information continued

Child lives with:

☐ One parent/guardian ☐ Two parents/guardians in the same household

☐ Two parents/guardians in two households – Does one household have primary legal custody?

☐ Yes - which parent has primary custody (write name)? _____ ☐ No - does one parent receive child support payments from the other household?

☐ Yes - which parent receives the child support payments (write name)? _____ ☐ No

What is the **total number** of family members living in your home, including yourself and your child? _____ **Staff only: Fam Size:** _____

Please list the people living in your home below, not including yourself or your 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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you, your child, or another person living in your home who is related to you by blood, marriage, or adoption receive these types of Public Assistance? Check all that apply:

☐ SSI for disability – Who receives? ☐ Child ☐ Parent/Guardian ☐ Other – Relationship to child: _____

☐ Temporary Assistance for Needy Families (TANF) cash. Check if you also have the following: ☐ Child-only TANF ☐ WorkFirst ☐ Working Connections Child Care subsidy

What is your **total estimated** household income for the last calendar year or the last 12 months? _____

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, etc.)

☐ In someone else's house or apartment with another family: ☐ Other – Please describe: _____

- ☐ By choice (e.g. save money for future plans, be close to family)
- ☐ Due to loss of housing, economic hardship, or similar reason

How did you hear about our program? Check all that apply:

- ☐ Website ☐ Community event ☐ Site staff ☐ Community agency/case worker (write name): _____
- ☐ Media ☐ Word of mouth ☐ Past parent ☐ Other – Please specify: _____
- ☐ Flyer

Parent/guardian, please sign on the next page.



WASHINGTON STATE
Department of
Children, Youth, and Families

Revised 03/01/2019

08.001.95

Page 5 of 6

Language: English

Early Learning Application 2019-2020

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:

- 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)

STAFF ONLY			
Child's Age:	Total Verified Family Size:	Total Verified Income:	Total Points:
Site Name/ID: FPELC2160		Date received:	
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 mother's slot? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, mother's name: _____	
FOR HOMELESS FAMILIES - Check the services that are needed or desired by the family and provide resources as soon as possible:			
<input type="checkbox"/> Child care resources	<input type="checkbox"/> Immunization/medical records	<input type="checkbox"/> Medical/DSHS services – Food stamps/TANF	
<input type="checkbox"/> Clothing resources	<input type="checkbox"/> Vision referral	<input type="checkbox"/> College/vocational/technical resources	
<input type="checkbox"/> School supplies	<input type="checkbox"/> Hygiene products/toiletries	<input type="checkbox"/> School transportation (if site provides)	
<input type="checkbox"/> Medical/dental referral	<input type="checkbox"/> Food resources	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Housing/shelter referral	<input type="checkbox"/> Birth certificate	_____	
Staff Name & Signature: _____		Date: _____	

Ask the family this question, required in ELMS: "If you could choose the length of day for your child's preschool, which is best for your child and family?"

- ☐ Part Day – 3 hours, 3-4 days a week
- ☐ Full School Day – 6 hours, 4-5 days a week
- ☐ Extended Day – available all day, all year, like a child care center

Explain that this is for information-gathering only and that these options may not all be available at your center/site.