

Welcome! Please complete one application packet per child and attach the required documents.
Eligibility to our programs is determined by child's age and family income, not by the date you applied.

Our programs fill up fast, so please apply as soon as you can!

The information on your application is confidential and used only to determine your child's eligibility for our Early Learning Programs.

We do not require, check, or report on immigration or DSHS status.

REQUIRED DOCUMENTS

Please contact us if you need help to complete the application or if you do not have all of the required documents listed below.

1



Application: Fill out the application form using a black or blue pen.

2



Proof of Income: Attach a copy of your proof of family income.

Use all that apply:

- Last year's Income Tax Return
- Last year's W-2 Form
- Pay stubs from the last 12 months
- SSI/TANF benefits letters from the last 12 months
- Foster care grant
- Child support
- Employer letter stating your total gross income from the last 12 months

3



Proof of Family Size: Attach a copy of proof of family size.

Use one of these:

- Last year's Income Tax Return
- Rental or housing document
- Benefits letter (TANF, SSI, etc.)
- School records
- Court or legal document

4



Proof of Child's Age: Attach a copy of your child's proof of birth date.

Use one of these:

- Birth Certificate
- Passport/Visa
- Adoption Papers
- Foster Care Authorization Letter
- Current Immunization Record
- DOC residential parenting roster

5



Proof of Legal Guardianship: Attach a copy of your proof of legal guardianship.

Use one of these:

- Birth Certificate
- Passport/Visa
- Adoption Papers
- Foster Care Record
- Written agreement signed and dated by parent and person assuming custodial responsibility

- Please make sure that your proof of income is included. We cannot process your application without this information.
- Call our office if you receive other types of documents, not listed above.
- It would be helpful to also include the following:
 1. A copy of your child's current immunization record
 2. Current IFSP/IEP, if applicable
 3. Most recent well-child exam
 4. Most recent dental exam

Return your completed application and documents to:

Address:

Cascade View ECEAP
13601 32nd AVE S
Tukwila, Wa 98168

Phone Number:

(206)901-7743

Early Learning Application 2019-2020

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 _____



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Child Health and Development Information continued

Did this child have a dental exam within the last 6 months? Yes – Date of last exam (month/day/year): _____ No 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?
 Yes – Please describe: _____ No

What is your child's immunization status? Fully immunized Exempt Not fully immunized or exempt

Do you have concerns about your child's health? Yes – check all that apply below No

Low birth weight (less than 5.5 lbs/5 lbs 8 oz.) Drug/alcohol affected
 Hearing Fine motor/gross motor
 Vision Mental health – Describe: _____
 Tooth pain/decay/bleeding gums Food intolerance/special diet – Describe: _____

Does your child have a current Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)? Yes No
If yes, check all the categories of the IEP/IFSP and include a copy with your application:

Autism Intellectual disability Specific learning disability
 Deaf-blindness Multiple disabilities Speech/language impairment
 Developmental delay Orthopedic impairment Traumatic brain injury
 Emotional disturbance Other health impairment Visual impairment
 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? Yes No I don't know

If no, do you **suspect** that your child has a developmental delay or disability?
 Yes – Speech/language No
 Behavior – Describe: _____
 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? _____



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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:		
<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"/> 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		



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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? _____

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.

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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:		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"/> Medicaid/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: _____	

