

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 this child's home language? _____	2 nd language: _____
Does this child speak: <input type="checkbox"/> Only English <input type="checkbox"/> Mostly English and another language <input type="checkbox"/> Some English, but mostly another language	
<input type="checkbox"/> Both English and another language the same (bilingual) <input type="checkbox"/> Only a language other than English	

Is this child Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is this child's race? Check all that apply:	
<input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above: _____
What is your family's heritage/tribe/country of origin? _____	

Has this child been previously enrolled in these programs? Only check the most recent :		
<input type="checkbox"/> None <input type="checkbox"/> Early Support for Infants and Toddlers (ESIT) or any Birth-to-Three/Home Visiting program	<input type="checkbox"/> Head Start/Early Head Start/ECEAP in King or Pierce County, Washington State <input type="checkbox"/> Head Start/Early Head Start/ECEAP in another Washington State County	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this child a sibling of a currently enrolled child at this site? <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 this child in official foster care or kinship care with a grant amount? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what is the Case Number or Client ID Number? _____	
What is the 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 this child in kinship care without a grant amount? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was this child adopted after foster care or kinship care or from orphanage from another country? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was this child recently reunited with their parent(s) after foster care or kinship care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your family currently receive services through Child Protective Services (CPS), Family Assessment Response (FAR), Indian Child Welfare (ICW) or law enforcement/court system? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your family received services from CPS/FAR/ICW or law enforcement/court system in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your family currently approved for childcare through CPS or FAR?	
<input type="checkbox"/> Yes – How many approved hours per week? _____ <input type="checkbox"/> No	
Has this child ever been asked to leave an early learning program because of behavior issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Child Information – Health

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

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

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

Has a Health Care Provider diagnosed this child with 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

Child Information - Development

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.) Preterm birth less than 37 weeks Drug/alcohol affected
 Hearing Fine motor/gross motor Tooth pain/decay/bleeding gums
 Vision Food intolerance/special diet –
Please describe: _____

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.

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Parent/Guardian Information

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	<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 (include City, State, Zip)	_____	_____
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
What language(s) do you speak?	_____	_____
Do you need an interpreter for this language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your race? Check all that apply	<input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above: _____	<input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above: _____
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



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	Parent/Guardian 1	Parent/Guardian 2
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"/> No, retired or 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"/> No, retired or 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 or have been in the U.S. military?	<input type="checkbox"/> Yes, current service member <input type="checkbox"/> Yes, currently deployed or have been in the last 12 months/for a total of 19 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No	<input type="checkbox"/> Yes, current service member <input type="checkbox"/> Yes, currently deployed or have been in the last 12 months/for a total of 19 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No

Family Concerns

Please check areas of concern that you have for yourself/family in your household:

<input type="checkbox"/> Household member has a disability or has a chronic physical or mental health condition and is:	<input type="checkbox"/> Household domestic violence (past or current), including <i>in utero</i>	<input type="checkbox"/> Child's parent/guardian is a migrant worker
<input type="checkbox"/> Unable to engage in work/school/family life	<input type="checkbox"/> Household drug/alcohol issues or substance abuse (past or current), including <i>in utero</i>	<input type="checkbox"/> Recent immigrant/refugee (past 5 years)
<input type="checkbox"/> Somewhat able to engage in work/school/ family life	<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 incarcerated
<input type="checkbox"/> Mostly able to engage in work/school/family life	<input type="checkbox"/> Child's parent/guardian concern for getting or keeping a job	<input type="checkbox"/> Loss of a parent (death, abandonment, or deportation)
<input type="checkbox"/> Child's parent/guardian has learning difficulties, no disability	<input type="checkbox"/> Family has legal concerns	<input type="checkbox"/> Child's parents/guardians divorced or separated during child's life
		<input type="checkbox"/> Family previously homeless (in the last 12 months)
		<input type="checkbox"/> Family concerns with housing

Family Living Situation

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.**

<input type="checkbox"/> Rent	<input type="checkbox"/> In a motel	<input type="checkbox"/> A car, park, campsite, or similar location	<input type="checkbox"/> Moving from place to place/couch surfing
<input type="checkbox"/> Own	<input type="checkbox"/> In a shelter	<input type="checkbox"/> Transitional Housing	<input type="checkbox"/> In a residence with inadequate facilities (no water, heat, electricity)
<input type="checkbox"/> In someone else's house or apartment with another family:		<input type="checkbox"/> Other – Please describe: _____	
➢ <input type="checkbox"/> By choice (e.g., to save money, to be close to family, etc.)			
➢ <input type="checkbox"/> Due to loss of housing, economic hardship, or similar reason			



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Family Income and Family Size

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.

Check all that apply if your family receives the following:

- Child-only TANF WorkFirst Working Connections Child Care subsidy SNAP WIC

Were you referred to this program by an agency? Yes: _____ No

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?
_____	_____	_____	<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

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)

***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 mother's slot? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, mother's name: _____			
Section 2: For McKinney-Vento Act children/families. Check services the family received. Staff should provide resources within 24-48 hours.			
<input type="checkbox"/> Childcare 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: _____	

