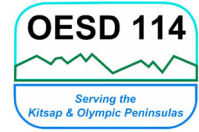


# Early Learning Application 2022-2023



**Completing this application expresses your interest in one of our programs and does not guarantee enrollment. You will be contacted by an OECD Early Learning Eligibility Coordinator to verify and confirm eligibility, best placement, and enrollment possibilities when space is available.**

How Heard: Please indicate how family heard about OECD Early Learning EHS/ECEAP/Head Start		
<input type="checkbox"/> Agape <input type="checkbox"/> Banner/Yard Sign <input type="checkbox"/> Caseworker <input type="checkbox"/> Community Event: <input type="checkbox"/> DCYF <input type="checkbox"/> DSHS <input type="checkbox"/> Early Learning Employee: <input type="checkbox"/> Email/Newsletter <input type="checkbox"/> Enrolled Family Referral: <input type="checkbox"/> Facebook	<input type="checkbox"/> Flyer <input type="checkbox"/> Holly Ridge <input type="checkbox"/> KIAC <input type="checkbox"/> Kitsap Community Resources <input type="checkbox"/> KPHD <input type="checkbox"/> Library <input type="checkbox"/> Macaroni Kid <input type="checkbox"/> Mailing/Postcard <input type="checkbox"/> Media <input type="checkbox"/> Medical Professional	<input type="checkbox"/> Other Community Agency: <input type="checkbox"/> PCAP <input type="checkbox"/> Peachjar <input type="checkbox"/> Returning Family <input type="checkbox"/> School District: <input type="checkbox"/> Website: <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other:

Program option interested in (Check all that apply):

<input type="checkbox"/> Part-Day a.m.	<input type="checkbox"/> Part-Day p.m.	<input type="checkbox"/> Extended/School-Day
<input type="checkbox"/> Working-Day	<input type="checkbox"/> Early Head Start	

## 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 <sup>nd</sup> 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 Specify:
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: _____
Is this child a member of sovereign tribal nation that have a government-to-government relationship with the U.S. government?
<input type="checkbox"/> Yes <input type="checkbox"/> No Name of sovereign tribal nation: _____



# OESD Early Learning Application 2022-2023

Has this child been previously enrolled in these programs? Only check the **most recent**: *(consent to verify, verification required)*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> OESD Early Head Start/Head Start/ECEAP                   | <input type="checkbox"/> Early Head Start/Head Start/ECEAP in another Washington State County or State | <input type="checkbox"/> Migrant/Seasonal Head Start anywhere in Washington State |
| <input type="checkbox"/> Any Birth-to-Three Home Visiting program                 | <input type="checkbox"/> Early ECEAP   | <input type="checkbox"/> ECLIPSE  |
| <input type="checkbox"/> Early Support for Infants and Toddlers (ESIT)            |  |   |
| <input type="checkbox"/> Part C Early Intervention Program (EIP) in another state |  |   |

When did this child last attend? \_\_\_\_\_ Name and location of program: \_\_\_\_\_

Is this child a **sibling** of a currently enrolled child at this site?  Yes  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?  Yes  No

**If yes**, what is the Case Number or Client ID Number? \_\_\_\_\_

What is the monthly grant/payment amount and source? \$ \_\_\_\_\_  DSHS  SSI  Tribe  Other

# of children covered by grant amount: \_\_\_\_\_

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 through Child Protective Services (CPS), Family Assessment Response (FAR), Indian Child Welfare (ICW) or law enforcement/court system?  Yes  No

Has your family received services from CPS/FAR/ICW 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

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 a dental exam within the last 6 months?

Yes – Date of last exam (month/day/year): \_\_\_\_\_

No  Date Unknown



# OESD Early Learning Application 2022-2023

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

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.**

IEP Start: \_\_\_\_\_ IEP End: \_\_\_\_\_ School District Issued IEP: \_\_\_\_\_

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.

IEP/IFSP is for:

Autism

Intellectual disability

Specific learning disability

Deaf-blindness

Multiple disabilities

Speech or language impairment

Developmental delay

Orthopedic impairment

Traumatic brain injury

Emotional disturbance

Other health impairment

Visual impairment

Hearing impairment

This child will receive IEP services:

Within the ECEAP classroom only

During ECEAP hours only, but outside the ECEAP classroom

Outside ECEAP hours

# OESD Early Learning Application 2022-2023

## 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
First & Last 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)		
Physical Address (include City, State, Zip)		
Mailing Address (include City, State, Zip)	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A
Phone	<input type="checkbox"/> Landline <input type="checkbox"/> Work <input type="checkbox"/> Cell Opt In: Y / N	<input type="checkbox"/> Landline <input type="checkbox"/> Work <input type="checkbox"/> Cell Opt In: Y / N
Alternate Phone	<input type="checkbox"/> Landline <input type="checkbox"/> Work <input type="checkbox"/> Cell Opt In: Y / N	<input type="checkbox"/> Landline <input type="checkbox"/> Work <input type="checkbox"/> Cell Opt In: Y / N
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 <b>highest</b> level of education you completed?	<input type="checkbox"/> 6 <sup>th</sup> grade or less <input type="checkbox"/> College/Prof Cert <input type="checkbox"/> 7 <sup>th</sup> -12 <sup>th</sup> grade, no diploma or GED <input type="checkbox"/> Associate <input type="checkbox"/> High school diploma <input type="checkbox"/> Bachelors <input type="checkbox"/> GED <input type="checkbox"/> Master/Doctorate <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> None	<input type="checkbox"/> 6 <sup>th</sup> grade or less <input type="checkbox"/> College/Prof Cert <input type="checkbox"/> 7 <sup>th</sup> -12 <sup>th</sup> grade, no diploma or GED <input type="checkbox"/> Associate <input type="checkbox"/> High school diploma <input type="checkbox"/> Bachelors <input type="checkbox"/> GED <input type="checkbox"/> Master/Doctorate <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> None



# OESD Early Learning Application 2022-2023

	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, active duty U.S. Military <input type="checkbox"/> Yes, currently deployed or have been in the past 12 months/for a total of 19 months <input type="checkbox"/> Yes, recently transferred for military or PCS in the past 12 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No	<input type="checkbox"/> Yes, active duty U.S. Military <input type="checkbox"/> Yes, currently deployed or have been in the past 12 months/for a total of 19 months <input type="checkbox"/> Yes, recently transferred for military or PCS in the past 12 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No

## 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.**

Rent     In a motel     A car, park, campsite, or similar location     Moving from place to place/couch surfing  
 Own     In a shelter     Transitional Housing     In a residence with inadequate facilities (no water, heat, electricity)

In someone else's house or apartment with another family:     Other – Please describe: \_\_\_\_\_  
 >  By choice (e.g., to save money, to be close to family, etc.)  
 >  Due to loss of housing, economic hardship, or similar reason

**Third Party Verification:** If you checked any of the boxes under **Family Living Situation**, may OESD have permission to contact a person or agency or can verify your information? **If no, documentation supporting living situation or a personal statement is required.**

Yes      Legal Guardian signature \_\_\_\_\_       No

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Affiliation (grandparent, shelter, etc.): \_\_\_\_\_



# OESD Early Learning Application 2022-2023

## Family Concerns

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

<input type="checkbox"/> Parent or child ever experienced emotional, physical, or sexual abuse/neglect including domestic violence (past or current), <i>including in utero</i>	<input type="checkbox"/> Household member has a disability <b>or</b> has a chronic health condition	<input type="checkbox"/> Concerns with food security
<input type="checkbox"/> Not homeless now, but was homeless within the last 12 months	<input type="checkbox"/> Severely / <input type="checkbox"/> Moderately: impacts ability to engage in work/school/family life	<input type="checkbox"/> Child's parent/guardian is a migrant worker or seasonal agricultural worker
<input type="checkbox"/> Family member attended an Indian boarding school	<input type="checkbox"/> Household member has mental illness (current or history of, incl maternal depression)	<input type="checkbox"/> Recent immigrant/refugee (past 5 years)
<input type="checkbox"/> Child's parent/guardian is incarcerated	<input type="checkbox"/> Severely / <input type="checkbox"/> Moderately: impacts ability to engage in work/school/family life	<input type="checkbox"/> Family lacks reliable transportation and/or proximity to centers
<input type="checkbox"/> Loss of a parent (death, abandonment, or deportation)	<input type="checkbox"/> Household drug/alcohol issues or substance abuse (past or current), including <i>in utero</i>	<input type="checkbox"/> Family has other mitigating risks (e.g. multiple chronic health conditions)
<input type="checkbox"/> Child's parent/guardian lacks medical or dental insurance		<input type="checkbox"/> Family has other concerns that induce fear (e.g. deportation, domestic violence, housing concerns, getting or keeping a job)

## 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:

Supplemental Security Income (SSI) for disability received by:  Child  Parent/Guardian  Other – Relationship to child:

Temporary Assistance for Needy Families (TANF) cash.

Supplemental Nutrition Assistance Program (SNAP) EBT food assistance

Check all that apply if your family receives the following:

Child-only TANF  WorkFirst  Working Connections Child Care subsidy  WIC

Were you referred to this program by an agency?  Yes, Agency Name: \_\_\_\_\_  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** in your family (including you) for whom you provide financial support?

What is the **total number** of people living in the house?

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



# OESD Early Learning Application 2022-2023

## Income Received by Child's Parent(s) or Guardian(s)

For children in foster care, kinship care or adopted after kinship care, fill in this box and skip to next section.

- Monthly grant or payment for foster care, kinship care, or adoption support \$ \_\_\_\_\_
- Number of children covered by this grant or payment: \_\_\_\_\_
- Case number or Client ID#, if any: \_\_\_\_\_
- Payment source (check):  DSHS  SSI  Tribe  Other: \_\_\_\_\_

Did you receive income during the last calendar year or during the previous 12 months?  Yes  No

If no, provide the reason there is no income and explain how basic needs are met: \_\_\_\_\_

## Enter all family income for one year in the chart below.

Select either:  Previous calendar year  Previous 12 months

Person with Income (Name)	Type of Income	Weekly Amount	# of Weeks Received	Monthly Amount	# Months Received	Annual Amount
	W-2					\$
	W-2					\$
	Tax return (1040) or IRS transcript – total income (line 9)					\$
	Tax return (1040) or IRS transcript – total income (line 9)					\$
	Pay stubs for 12 months					\$
	Pay stubs for 12 months					\$
	Child Support received, if required by a child support order			\$		\$
	Disability income, including SSI			\$		\$
	Military Leave & Earnings Statement (LES). Count all pay and allowances except BAH, BAS, FSH, and HFP/IDP.			\$		\$
	Self-employment net income					\$
	Social Security or other retirement benefits			\$		\$
	State or Tribal TANF Grants			\$		\$
	Unemployment	\$				\$
	Workers Compensation (L&I)	\$				\$
	Tribal Income (taxable)					\$
	Emergency Assistance Cash Payments			\$		\$
	Insurance Payments that are regular (not 1 time)			\$		\$
	Retirement or pension plans					
	Training Stipend					
	Scholarship, Grants, or Fellowships for living expenses					
					<b>SUBTOTAL</b>	
<b>SUBTRACT</b>	Child support paid to another household, if required by a legally-binding child support order			\$		\$
					<b>TOTAL</b>	



# OESD Early Learning Application 2022-2023

Do you still receive the income on the previous page Yes No *If yes, skip to signature section.*

If no, and your circumstances have recently changed, please explain: \_\_\_\_\_

Loss of wage earner

Divorce or separation

Unplanned job loss

Reduced work hours

Health/Injury

Loss of benefits

Job loss – lack of access or ability to afford child care for newborn

Similar unexpected circumstance (explain): \_\_\_\_\_

What is your monthly income? \$ \_\_\_\_\_

For which month? \_\_\_\_\_

**\*Staff Only –**

**Staff Initials:**

Verified revised income with: Childcare resources

Unemployment

Other: \_\_\_\_\_



# OESD Early Learning Application 2022-2023

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 Olympic Educational Service District (OESD). DCYF and OESD 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.

I agree that OESD Early Learning can share my information with local school districts in an effort to find the best fit for me and my family.

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

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)

**Survey for Statewide Planning:** If you could choose the length of day for your child’s preschool, which is best for your child and family? *Please note, these options may not all be available in your community this year.*

- Part Day - about three hours, three or four days a week.
- School Day - about six hours, four or five days a week.
- Working Day - available all day, all year, like a child care center.

## OESD Early Learning Staff Only

**Section 1:** Staff who finalize and determine eligibility complete this section before placing on the Waitlist

Child’s Age:	Total Verified Family Size:	Total Verified Income:	Total Points:
Site Name/ID:		Date received: (This date will determine eligibility timeframe)	

**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"/> Other: _____
<input type="checkbox"/> Medical/dental referral	<input type="checkbox"/> Food resources	
<input type="checkbox"/> Housing/shelter referral	<input type="checkbox"/> Birth certificate	
Staff Name & Signature:		Date:

