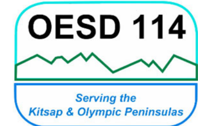
Early Learning Application 2023-2024

A PROGRAM OF



Completing this application expresses your interest in one of our programs and does not guarantee enrollment. You will be contacted by an OESD 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 OESD Early Learning EHS/ECEAP/Head Start		
☐ Agape	☐ Flyer	☐ Other Community Agency:
☐ Banner/Yard Sign	☐ Holly Ridge	☐ PCAP
☐ Caseworker	☐ KIAC	☐ Peachjar
☐ Community Event:	☐ Kitsap Community Resources	☐ Returning Family
☐ CSO	☐ KPHD	☐ School District:
☐ DCYF	☐ Library	☐ Website:
☐ DSHS	☐ Macaroni Kid	☐ Word of Mouth
☐ Early Learning Employee:	☐ Mailing/Postcard	☐ Other:
☐ Email/Newsletter	☐ Media	
☐ Enrolled Family Referral:	☐ Medical Professional	
☐ Facebook		

Program option interested in (Check all that apply): ☐ Part-Day a.m. ☐ Part-Day p.m. ☐ Extended/School-Day ☐ Working-Day ☐ Early Head Start ☐ Prenatal Application **(Complete yellow sections)** EDD: ______________

Preference for eligibility interview: ☐ In-Person ☐ Audio or Video Call

Family Income: $__________

We will need to verify your income by submitting documentation this can be electronically uploaded or submitted in person.

Does this child have a **current and active** Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?
☐ Yes ☐ No.

Child Information – General

First Name:	Middle Initial:	Last Name:
Date of Birth (month/day/year):		Gender: ☐ M ☐ F

What is this child's home language? 2nd language:

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

Is this child Hispanic/Latino? ☐ Yes ☐ No Specify Ethnicity: __________ ☐ Declined to report child's ethnicity

What is this child's race? Check all that apply:

☐ African/African American/Black	☐ Native Hawaiian or Pacific Islander
☐ Asian	☐ White
☐ Alaska Native/Native American/American Indian	☐ Not listed above: __________

☐Declined to report child's race	

Is this child a member of sovereign tribal nation that have a government-to-government relationship with the U.S. government?

☐ Yes ☐ No Name of sovereign tribal nation: ___________

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

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

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

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

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:

☐ Child was determined eligible for special education services through evaluation by a school district or tribal school, but parent/guardian declined services.

☐ Child completed a developmental screening that recommended referral for further evaluation

☐ Child has a suspected developmental delay or disability. (No IEP, diagnosis, or screening, or completed developmental screening with result, "rescreen needed".)

IEP/IFSP is for:

☐Autism
☐Deaf-blindness
☐Developmental delay
☐Emotional disturbance
☐Hearing impairment
☐Intellectual disability
☐Multiple disabilities
☐Orthopedic impairment
☐Other health impairment
☐Specific learning disability
☐Speech or language impairment
☐Traumatic brain injury
☐Visual impairment

This child will receive IEP services:

☐Within the ECEAP classroom only
☐Outside ECEAP hours
☐During ECEAP hours only, but outside the ECEAP classroom

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	☐ Biological/Adopted/Stepparent ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other:	☐ Biological/Adopted/Stepparent ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other:
Gender	☐ M ☐ F ☐ Not specified	☐ M ☐ F ☐ Not specified
Date of Birth (month/day/year)		
Physical Address (include City, State, Zip)		
Mailing Address (include City, State, Zip)	☐ N/A	☐ N/A
Phone	☐ Landline ☐ Work ☐ Cell Opt In: Y / N	☐ Landline ☐ Work ☐ Cell Opt In: Y / N
Alternate Phone	☐ Landline ☐ Work ☐ Cell Opt In: Y / N	☐ Landline ☐ Work ☐ Cell Opt In: Y / N
Email		
Were you under age 18 when this child was born?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
What language(s) do you speak?		
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: ___________	☐ African/African American/Black ☐ Asian ☐ Alaska Native/Native American/American Indian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Not listed above: ___________
What is the **highest** level of education you completed?	☐ 6th grade or less ☐ College/Prof Cert ☐ 7th-12th grade, no diploma or GED ☐ Associate ☐ High school diploma ☐ Bachelors ☐ GED ☐ Master/Doctorate ☐ Some college/advanced training ☐ None	☐ 6th grade or less ☐ College/Prof Cert ☐ 7th-12th grade, no diploma or GED ☐ Associate ☐ High school diploma ☐ Bachelors ☐ GED ☐ Master/Doctorate ☐ Some college/advanced training ☐ None

	Parent/Guardian 1	Parent/Guardian 2
Are you currently employed?	☐ Yes – How many hours per week (including travel)? ____________________ Employer name & phone #: ____________________ ☐ No ☐ No, retired or disabled ☐ Seasonal	☐ Yes – How many hours per week (including travel)? ____________________ Employer name & phone #: ____________________ ☐ 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)? ____________________ School name & major/goal: ____________________ ☐ No	☐ Yes – How many hours per week (including class time, study time, travel)? ____________________ School name & major/goal: ____________________ ☐ No
Are you in an approved WorkFirst activity?	☐ Yes – Describe the activity and the number of approved hours per week: ____________________ ☐ No	☐ Yes – Describe the activity and the number of approved hours per week: ____________________ ☐ No
Are you or have been in the U.S. military?	☐ Yes, active duty U.S. Military ☐ Yes, currently deployed or have been in the past 12 months/for a total of 19 months ☐ Yes, recently transferred for PCS in the past 12 months ☐ Yes, veteran ☐ No	☐ Yes, active duty U.S. Military ☐ Yes, currently deployed or have been in the past 12 months/for a total of 19 months ☐ Yes, recently transferred for military or PCS in the past 12 months ☐ Yes, veteran ☐ 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 due to loss of housing, economic hardship, or similar reason

☐ Other – Please describe: __________

☐ Doubled-up in a cooperative living arrangement with relatives or friends

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.):_______________________

Family Concerns

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

☐ Parent or child ever experienced emotional, physical, or sexual abuse/neglect including domestic violence (past or current), *including in utero*

☐ Not homeless now, but was homeless within the last 12 months

☐ Family member attended an Indian boarding school

☐ Child ever experienced parent/guardian incarcerated in jail, prison, or a detention center

☐ Loss of a parent (death, abandonment, or deportation)

☐ Child's parent/guardian lacks medical or dental insurance

☐ Household member has a disability **or** has a chronic health condition

- ☐ Severely / ☐ Moderately: impacts ability to engage in work/school/family life

☐ Household member has mental illness (current or history of, including maternal depression)

- ☐ Severely / ☐ Moderately: impacts ability to engage in work/school/family life

☐ Household drug/alcohol issues or substance abuse (past or current), including *in utero*

☐ Parent did not receive prenatal care in first trimester

☐ Concerns with food security

☐ Child's parent/guardian is a migrant worker or seasonal agricultural worker

☐ Recent immigrant/refugee (past 5 years)

☐ Family lacks reliable transportation and/or proximity to centers

☐ Family has other mitigating risks (e.g. multiple chronic health conditions)

☐ Family has other concerns that induce fear (e.g. deportation, domestic violence, housing concerns, getting or keeping a job)

☐ Single parent household

☐ Parents divorced/separated during child's life

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?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ 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?

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					
					SUBTOTAL	
SUBTRACT	Child support paid to another household, if required by a legally-binding child support order			$		$
					TOTAL	

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: _________

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.

Child's Full First & Last Name ____

Parent/Guardian Signature ____ **Date** ________________

Parent/Guardian Signature ____ **Date** ________________

Witness/Interpreter 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.

☐ Childcare 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 ☐ Other: _________

Staff Name & Signature:	**Date:**

Washington State Department of CHILDREN, YOUTH & FAMILIES