



## Accepting Applications for (Birth to Five)

### *Head Start/Early Head Start and Early Childhood Education and Assistance Program (ECEAP)*

Dear Families,

**The Head Start** and Early Childhood Education and Assistance Program (**ECEAP**) of Whitman County want to invite you to enroll your child in our local preschool program. Classes meet at sites throughout Whitman County with no charge to qualifying families. St. James is a full year extended day program (7:30-5:30) (parents must be working/going to school), Colfax is four days, (M-Th, 8:00 to 2:30) and all other sites are four days a week, 3 to 3 ½ hours a day. Your child will have fun while mastering preschool skills and preparing for kindergarten. Priority will be given to children who will turn three or four years old by August 31, 2017. However, children who turn three years old after this date will be considered.

**Early Head Start** is a federally funded program for low-income families with infants, toddlers and expecting mothers. Early Head Start is a Home Based/full year program. Home visitors staff will provide 90-minute home visits to support parents as their child's first and for most teachers. Additionally, twice a month families will have socialization play groups to promote social and learning skills for both children and their parents.

Most families must meet specific income guidelines in order to qualify for the program. Attached is an application to begin the process of enrolling your child. **You must complete the application form, submit income and age proof if you would like your child considered for Head Start/EHS or ECEAP.**

Any information we are given is kept in strict confidence.

Thank you for your interest in the Head Start / EHS and ECEAP programs. If you have a friend who is interested in these programs or if you need help completing the application, please call at (509) 334-9290, toll free at (877) 909-7005 or fax to (509) 332-5108. We look forward to meeting your family!

Sincerely,

Mona Younes  
Enrollment Recruitment Specialist

Please fill out the enclosed application and send us verification of your income and your child's age so we can complete the enrollment process.

Income can be verified by any of the following documents:

1. If employed, you may send a copy of your 2016 income tax, W-2, or pay stubs for the past twelve months.
  2. TANF Benefit History Listing/Foster Child Payment (this may be provided by your caseworker).
  3. Child support order or support enforcement payment printout.
  4. Financial aid award papers. (Form 1098-T Tuition Statement from your college)
  5. If you are not employed and do not receive any of the above support, please state the source of your income and provide proof: \_\_\_\_\_
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Your child's date of birth may be verified by any of the following documents:

1. A copy of their birth certificate (hospital or live birth certificate).
2. Visa or passport.
3. Baptism records.
4. Medical coupon
5. Immunization records from medical facility

Please send copies of these documents, do not send originals! The information that you provide is confidential and will not be used for any other purpose except to verify the eligibility of your child for the program. We will be in touch with your family to let you know your eligibility status. If you have any questions, please call us at (509) 334-9290 or toll free at (877) 909-7005.

**Please be aware that any family member who intentionally attempts to provide or provides false information will result in the termination of the application.**



### ECEAP/Head Start/EHS Application

The Department of Early Learning keeps the identity of individual children and families confidential to the extent allowed by state and federal law.

#### 1. Child Information

Child's birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Legal First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Legal Last Name \_\_\_\_\_

Gender: M F

Is this child on an Individualized Education Program (IEP)?  Yes  No

If no, do you have any concerns about this child's development?  Yes  No

Is this child in licensed foster care? Yes \_\_\_\_ No \_\_\_\_

Is this child's family currently receiving Child Protective Services (CPS)?  Yes  No

Is this child's family currently receiving Family Assessment Response (FAR) services?  Yes  No

Is this child homeless (does not have a fixed, regular, and adequate nighttime residence)? Yes \_\_\_\_ No \_\_\_\_

If yes, does this homeless child live with a parent or legal guardian? Yes \_\_\_\_ No \_\_\_\_

Is this child living with a guardian, who is not a parent or licensed foster parent, who receives a TANF grant on behalf of the child? Yes \_\_\_\_ No \_\_\_\_

Child's first language \_\_\_\_\_ Child's second language \_\_\_\_\_

Is this child Hispanic/Latino? Yes \_\_\_\_ No \_\_\_\_ if yes, please specify \_\_\_\_\_

What race (s) do you consider your child? Child's race (may choose more than one):

- Black or African American  White  American Indian (please specify) \_\_\_\_\_
- Alaska Native (please specify) \_\_\_\_\_  Asian (please specify) \_\_\_\_\_
- Native Hawaiian or Pacific Islander (please specify) \_\_\_\_\_  Biracial/Multiracial
- Other-Describe: \_\_\_\_\_  Unspecified

*For staff use only*

Name and Signature of CCCC staff viewing documents and verifying eligibility:

\_\_\_\_\_  
Staff Name

\_\_\_\_\_  
Staff Signature

**Child birth date** verified by viewing:

- Adoption papers
- Birth certificate
- Foster care authorization letter
- Government document with birth date
- IEP
- Immunization record
- Medical card (DSHS, military)
- Medical record of birth/hospital record
- Passport
- TANF award letter
- Other \_\_\_\_\_

## 2. Parent/Guardian Contact Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Gender: M    F  
Relationship to Child:  Parent (biological or adoptive)  Step Parent  Foster Parent  Grandparent  
 Other Relative  Other Legal Guardian  Other (specify) \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Mailing address (if different) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
County \_\_\_\_\_ School District \_\_\_\_\_  
Email \_\_\_\_\_  
Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
Do you need an interpreter to communicate with English speakers? Yes \_\_\_\_ No \_\_\_\_  
If yes, what language(s) do you speak? \_\_\_\_\_

**Additional Parents/Guardians:** *If address and phone numbers are different, please write below.*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Last Name \_\_\_\_\_

## 3. Child lives with:

- One parent/guardian Name \_\_\_\_\_
- Two parents/guardians in same household Names \_\_\_\_\_
- Two parents/guardians in two households – *If this is checked, complete these questions to determine which parents' income is counted for Program eligibility.*
- Does one household have primary legal custody? Yes \_\_\_\_ No \_\_\_\_  
If **yes**, which parent has primary custody? \_\_\_\_\_  
Spouse of parent with primary custody, if any: \_\_\_\_\_ **Skip to section 4.**
- If **no**, does one parent receive child support payments from the other household? Yes \_\_\_\_ No \_\_\_\_  
If **yes**, which parent receives the child support payments? \_\_\_\_\_  
Spouse of parent with primary custody, if any: \_\_\_\_\_ **Skip to section 4.**
- If **no**, name the legal parent/guardian that shares custody for each household. Do not include their spouses. For this family situation only, see \* in question 4 below.  
(Household 1) \_\_\_\_\_ (Household 2) \_\_\_\_\_

<p><b>Authority to enroll verified by viewing:</b></p> <p><input type="checkbox"/> Adoption papers</p> <p><input type="checkbox"/> Benefits letter showing guardian receives benefit on behalf of the child</p> <p><input type="checkbox"/> Birth certificate</p> <p><input type="checkbox"/> Court order, custody order</p> <p><input type="checkbox"/> Foster care record</p> <p><input type="checkbox"/> Guardian's income tax return listing child</p> <p><input type="checkbox"/> Insurance documents stating relationship</p> <p><input type="checkbox"/> Legal will, describing the relationship</p> <p><input type="checkbox"/> Letter from social worker, school personnel, lawyer, religious leader, or mental health professional</p> <p><input type="checkbox"/> Records from DSHS that show guardian as contact for the child</p> <p><input type="checkbox"/> Records from school, hospital, clinic, other public health, or social service agency</p> <p><input type="checkbox"/> Written agreement signed and dated by parent and person assuming custodial responsibility</p> <p><input type="checkbox"/> Other _____</p>
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**4. Family Size** – This is used to determine family’s federal poverty level, and may be different than the number of people in the house.

*\*If parents from two households are named in the question just above, include family members and income from both households. Divide final answer by 2.*

- a. In addition to the enrolling child, and the parent(s) named in question 3, how many additional children \_\_\_\_\_ and adults \_\_\_\_\_ live in the same household?
- b. Of the number just entered, how many people are supported by the income received by the parents named in question # 3: \_\_\_\_\_. If there is \$0 income for the household, enter the number from box 4a. \_\_\_\_\_
- c. Of the number just entered, how many people are related to the parent(s) named in question 3 by blood, marriage, or adoption? \_\_\_\_\_

*The “family size” for federal poverty level purposes is this number, plus the Enrolling child, plus parents named in #3.*

Family size verified by viewing:

- Benefits letter (TANF, SSI, etc.)
- Foster care grant (for child-only application)
- Tax records from previous year (1040)
- Rental/housing document
- Provider One health insurance
- Other \_\_\_\_\_

**5. Family Info: Household Members**

First Name	Last Name	Gender	Relationship to Child	Age	Birth date

**How did you find out about the ECEAP/Head Start/EHS?**

- DEL Website    Community Event    Flyer    ECEAP Employee    Word of Mouth    Media
- Case Worker    Community Agency   Name of Agency : \_\_\_\_\_    Other   Describe other: \_\_\_\_\_

## 6. Household Situation

- \*Does this household receive subsidized housing, such as a housing voucher or cash assistance for housing?  Yes  No
- \*Does this household currently receive a Working Connections child care subsidy for this child?  Yes  No
- \*Does this household receive Women, Infant, Children (WIC)  Yes  No
- \*Does this household receive Food Assistance (SNAP)  Yes  No

## 7-10. Supplemental Parent Activities

Answer the following questions for each parent/guardian	Parent/Guardian #1 Name _____	Parent/Guardian #2 Name _____
<b>7.</b> Is this parent/guardian <b>employed</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, enter number of hours per week in paid work plus work-related travel.		
b. If yes, enter employer name and phone or email.		
<b>8.</b> Is this parent/guardian enrolled and attending <b>school or job training</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, enter the total number of hours per week when school is in session. Include class time, up to 10 hours of study time, and travel time.		
b. If yes, enter name of school or training organization.		
c. If yes, enter goal or major.		
d. Anticipated graduation/Finish Date		
<b>9.</b> Is this parent/guardian in an approved <b>Work First activity</b> other than employment, education or job training mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, describe activity.		
b. If yes, enter number of hours per week in approved activity and related travel.		
<b>10.</b> Is family approved for <b>child care through Child Protective Services (CPS)</b> , including Family Assessment Response (FAR)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, enter number of approved hours per week.		

**11. Income Received by Child's Parent(s) or Guardian(s)**

<i>If this child is homeless and <u>not</u> living with a parent or guardian, skip to section 12.</i>	
<i>If this child is in foster care or covered by a child-only TANF grant (kinship care) fill in this information, then skip to section 12.</i> Monthly foster care or SSI grant for this child \$ _____ Case number _____ Monthly TANF grant: \$ _____ # of children on grant _____ TANF Client ID number _____	<b>Staff verified income by viewing:</b>  _____ _____

- Did this family receive income during the last calendar year or during the previous 12 months?  Yes  No  
 If no, describe reason family does not have income: \_\_\_\_\_
- Enter all family income for one year in the chart below.
  - Select either:  Previous calendar year  Previous 12 months

Name of person(s) receiving income	Document Verified	Weekly amount	# of weeks received	Monthly amount	# of months received	Annual Amount	Verified (v)
	W-2					\$	
	W-2					\$	
	Income Tax (1040-1040 A) or IRS transcript					\$	
	Pay stubs for 12 months					\$	
	Pay stubs for 12 months					\$	
	Social Security (OASI or SSDI) or other Retirement benefits			\$		\$	
	Workers Compensation (L&I)	\$					
	Disability income including SSI, for any family member			\$		\$	
	Child Support received by this household			\$		\$	
	Unemployment	\$				\$	
	TANF cash assistance			\$		\$	
	Child only-TANF or Foster Care Grant for a non-ECEAP child			\$		\$	
	Self-employment net income			\$		\$	
	Scholarships/grants/fellowships for living expenses						
	Military Leave & Earnings Statement (LES) Count all pay and allowances except BAH, BAS and HFP/IDP.					\$	
	Other income not classified above			\$		\$	
						\$	<b>Subtotal</b>
<b>Subtract</b>	Court order for Child Support paid to another household			\$		-\$	
						\$	<b>TOTAL</b>

**\*\*\*Please provide document proof of any income marked above.**

Do you still receive the income above?  Yes  No *If yes, skip to section 12.*

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

- Divorce or separation       Loss of job       Loss of wage earner  
 Loss of benefits     Other (explain) \_\_\_\_\_

What is your monthly income: \$ \_\_\_\_\_ For which month? \_\_\_\_\_

**Staff verified monthly income by viewing:**

\_\_\_\_\_  
\_\_\_\_\_

*Note: You must also verify annual income.*

## 12. Previous Enrollment

Was this child previously enrolled in Head Start (for preschoolers)?  Yes  No *If yes, where?* \_\_\_\_\_

Was this child enrolled in Early Head Start or a birth-to-three home visiting program?  Yes  No

Was this child enrolled in Early Support for Infants and Toddlers early intervention (ESIT or IFSP)?  Yes  No

Does this child have an Individualized Education Program (IEP)?  Yes  No

If no, do you have any concerns about this child's development? Explain: \_\_\_\_\_

If this child has an IEP check all categories of the IEP. If not, skip to next question.

- |  |  |  |
|--|--|--|
| <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 or 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 this child's IEP? \_\_\_\_\_

Has this child been asked to leave a child care or preschool because of behavior issues?  Yes  No

*(Head Start/EHS/ECEAP serves children with behavior issues. Checking yes will not exclude your child.)*



### 13. Additional Questions

*We use this information below to choose the children who need the program most. All responses are kept confidential. You may choose not to answer the questions below.*

- Is English a second language for this child (*speaks another language and is learning English*)?  Yes  No
- Has this child been abused /neglected physically, sexually or emotionally?  Yes  No
- Does this child have a parent who is developmentally or physically disabled?  Yes  No
- Does this child have a parent who is currently on active duty in the U.S. military?  Yes  No
- Does this child have a parent who is currently on active duty in the National Guard/Military Reserve?  Yes  No
- Does this child have a parent who is currently or was recently deployed to a combat zone?  Yes  No
- Does this child have a parent who is incarcerated in jail, prison or a detention center?  Yes  No
- Does this child have a parent experiencing mental health issues (including maternal depression)?  Yes  No
- Does this child have a parent who was under age 18 when this child was born?  Yes  No
- Does this child have a parent who is a migrant worker?  Yes  No
- Is the mother pregnant or has there been a newborn in the past 12 months?  Yes  No
- Has your family been homeless within the last 12 months?  Yes  No
- Has your family received services from Child Protective Services (CPS) in the past?  Yes  No
- Has your family ever experienced domestic violence?  Yes  No
- Has your family ever struggled with drugs or alcohol?  Yes  No
- Do you have a support system outside of your family (people you can talk with or who help you)?  Yes  No
- The program received a professional referral for this child  Yes  No

Name of referring agency: \_\_\_\_\_

**14. Parent Information: Check (v) each parent's highest level of education and part time or full time school/employment. (v)**

	<b>Employment</b>	Employed full-time	Employed part-time	Unemployed	<b>Education</b>	In educational program full-time	In educational program part-time	6 <sup>th</sup> grade or less	7 <sup>th</sup> to 12 <sup>th</sup> grade, no diploma or GED	High school diploma or GED	Some college	Associate degree	Bachelors degree	Masters degree or doctorate
Parent/Guardian #1 name _____														
Parent/Guardian #2 name _____														

**15. Health Information - Please attach a copy of the child's immunization record**

Does this child have a chronic health condition such as diabetes, asthma, seizures, etc?  Yes  No

If yes, please describe \_\_\_\_\_

Did this child weigh less than 5.5 pounds when they were born?  Yes  No  Unknown

Does this child have medical insurance or coverage?

- Washington Apple Health for Kids / Provider One Services Card  Military Coverage  
 Private Medical Insurance  Tribal Coverage  No medical coverage

Does this child have a regular doctor or medical clinic?  Yes  No  Unknown

Did this child have a well-child exam within the last 12 months)?  Yes  No  Unknown

Date of last well-child exam before applying for Program \_\_\_\_/\_\_\_\_/\_\_\_\_  Date Unknown

Does this child have dental insurance or coverage?

- Washington Apple Health for Kids / Provider One Services Card  Military Coverage  
 Private Dental Insurance  ABCD  Tribal Coverage  No dental coverage

Does this child have a regular dentist or dental clinic?  Yes  No  Unknown

Did this child have a dental screening within the last 6 months?  Yes  No  Unknown

Date of last dental screening before applying for Program \_\_\_\_/\_\_\_\_/\_\_\_\_  Date Unknown

**Immunization Status:**

Complete - child presented a signed Certificate of Immunization Status (CIS) form showing sufficient immunization dates to meet the schedule, or documented immunity.

Exempt - child presented a signed Certificate of Exemption (COE) form certifying that the child is exempt for one or more vaccines for medical, persona/philosophical or religious reasons.

Conditional - child presented a signed CIS form that does not meet the requirements, but has proof of initiation or continuation of a schedule of immunizations AND is within the recommended interval for the next dose.

Out of Compliance - child does not have a signed, completed CIS form.

Out of Compliance - child is not exempt and has not received immunization required for their age.

Child's signed Certificate of Immunization Status has not been evaluated.

**Signature of Parent/Guardian**

I certify that the information on this form is true and correct. I understand that this information may be reported to other state agencies or research firms.

Print name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_