



## 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 3:00) 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, 2018. However, children who turn three years old after this date will be considered for Head Start.

**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. Family consultants will provide 90-minute home visits once a week to support parents in their role as their child's first and foremost teacher. 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 2017 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M\_\_ F\_\_

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

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 state, tribal or SSI payment on behalf of the child? Yes \_\_\_\_ No \_\_\_\_

The child speaks (select one only):  Only English  Mostly English  Some English, but mostly another language

English and another language at age level (bilingual)  Only a home language other than English

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. Family Info: Household Members:** *Please list everyone in the household who may be counted in family size and supported by the parent's income of the enrolled child.*

First Name	Last Name	Relationship to enrolled child	Birth date

**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
- Signed application or parent statement
- Other \_\_\_\_\_

\*\*For person's age 19 years or older if the parents pay more than half of the living expenses COUNT that person in your household size.

\*\*For person's age 19 or older if the parents pay less than half of the living expenses DO NOT count them in your household size.

**3. Parent/Guardian Contact Information**

Do you need an interpreter to communicate with English speakers? Yes \_\_\_\_ No \_\_\_\_

If yes, what language(s) do you speak? \_\_\_\_\_

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 \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

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

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

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

**4. Child lives with:**

One parent/guardian Name \_\_\_\_\_ **(Skip to Section 5 )**

Two parents/guardians in same household Names \_\_\_\_\_ **(Skip to Section 5 )**

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 5 )**

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 5 )**

If **no**, **Program will count the income from the** legal parent/guardian for each household. Do not include their spouses. Enter the legal parents name below.

(Household 1) \_\_\_\_\_ (Household 2) \_\_\_\_\_

**Contact information for Household #2:**

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing address (if different) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**Authority to enroll** verified by viewing:

- Adoption papers
- Benefits letter showing guardian receives benefit on behalf of the child
- Birth certificate
- Court order, custody order
- Foster care record
- Guardian's income tax return listing child
- Insurance documents stating relationship
- Legal will, describing the relationship
- Letter from social worker, school personnel, lawyer, religious leader, or mental health professional
- Records from DSHS that show guardian as contact for the child
- Records from school, hospital, clinic, other public health, or social service agency
- Written agreement signed and dated by parent and person assuming custodial responsibility
- Other \_\_\_\_\_

**5. Parent Employment Training, and other Activities:**

Answer the following questions for each parent/guardian	Parent/Guardian #1 Name _____	Parent/Guardian #2 Name _____
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 of paid work plus work-related travel.		
b. If yes, enter employer name and phone or email.		
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		
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.		
Is family approved for <b>child care through Child Protective Services (CPS), FAR, or similar Tribal Funds</b> ?	<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.		

**6. 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: \_\_\_\_\_

### 7. 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 8</i>	
<i>If this child is in foster care or living with a guardian who receives a payment for the child fill in this box and then skip to Section 8.</i> Monthly grant or payment amount: \$ _____ Case # or Client ID #: _____ Monthly TANF grant: \$ _____ # of children on grant ____ Payment Source(circle): DSHS SSI TRIBE OTHER	<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.					\$	
	Tribal Income (taxable)						
	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 8.*

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

- Divorce or separation  Loss of job  Loss of wage earned  Job change  
 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.*

## 8. 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?  Yes  No

Any 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

## 9. IEP or Suspected Delay

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? \_\_\_\_\_

**10.** 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.)*



## 11. Additional Questions

*We use this information below to choose the children who need the program most. All responses are kept confidential.*

- Has this child been homeless within the last 12 months?  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
- 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  
If yes, name of referring agency: \_\_\_\_\_  Yes  No
- Has this child been abused /neglected physically, sexually or emotionally?  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

**12. 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	7th to 12th grade, no diploma or GED	High school diploma or GED	Some college	Professional Certificate (Vocational Schools)	Associate degree	Bachelors degree	Masters degree or doctorate
Parent/Guardian #1 name _____															
Parent/Guardian #2 name _____															

**13. 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

Name of clinic or provider: \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

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

Name of clinic or provider: \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

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.

**14. 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:

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

**15. 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 Care 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

**Signature of Parent/Guardian**

I certify that the information on this form is true and correct. I understand that, if I knowingly provide false information, my child could be disqualified from the Program. I understand that this information may be reported to other state agencies or research firms.

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

**Signature of Staff Member who verified eligibility**

I certify that, to the best of my knowledge, the information on this form is true and correct. I viewed and verified documentation establishing this child’s eligibility for the Program.

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