COMMUNITY CHILD CARE CENTER
530 NW Greyhound Way Pullman, WA 99163 (509) 334-9290
Head Start/EHS/ECEAP/Child Care

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 wants 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.

The St. James site is a 'Working day' ECEAP program (7:30-5:30) (parents must be working/going to school). The Colfax site, 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, 2020. However, children who turn three years old after this date will be considered.

Early Head Start (EHS) 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 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 these programs. Attached is an application to begin the process of enrolling your child. **You must complete the application form, submit income, age proof, and immunization records 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 2019 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:_____

_____

_____

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
6. Others

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 Children, Youth and Family keeps the identity of individual children and families confidential to the extent allowed by state and federal law.

1. Child Information

Legal First Name _____ Legal Last Name _____

Child's birth date ___/___/_____ Gender: M___ F___

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

CPS - Is this child's family actively involved in Child Protective Services (CPS), Family Assessment Response (FAR), or Indian Child Welfare (ICW) or law enforcement/court system regarding child abuse, neglect, or sexual assault? ☐ Yes ☐ No

Foster Care - Is this child in official foster care? (there is a caregiver authorization from a state or tribe that says this is a foster care placement). ☐ Yes ☐ No

Kinship - Is this child in kinship care with a relative or suitable other, with or without a grant? ☐ Yes ☐ No

Adopted after foster/kinship care - Was this child adopted after foster care, kinship care, or after living in an orphanage in another country (This does not include other adoptions) ☐ Yes ☐ No

Housing (select one):

☐ Rent or own an adequate residence

☐ Doubled-up with another family for convenience, choosing to be close to family or friends, or choosing to save money for future plans

☐ Doubled-up with another family due to loss of housing, economic hardship or a similar reason

☐ In an emergency or transitional shelter

☐ Sleeping in a hotel, motel, car, park, campsite or similar location

☐ Moving from place to place (couch surfing)

☐ Inadequate housing such as no water, heat or electricity; excessive mold; or no cooking facilities

For staff use only

Child birth date verified by viewing:

- ☐ Adoption Papers
- ☐ Birth Certificate
- ☐ Certificate of Degree of Indian Blood (CDIB)
- ☐ Child Profile
- ☐ Court Documents
- ☐ Foster Care Authorization Letter
- ☐ Government Document with Date of Birth
- ☐ IEP
- ☐ Immunization Record
- ☐ Medical Card or Records
- ☐ Medical Record of Birth
- ☐ Passport or Visa
- ☐ Paternity Affidavit
- ☐ Permanent Resident (Green) Card
- ☐ School Records
- ☐ Other

_____

Language: The child speaks (select one only): ☐ Only English ☐ Mostly English and some of another home language ☐ 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 (check all that apply):

☐ White ☐ Black or African American ☐ Alaska Native (**please specify**) _____

☐ American Indian (**please specify**) _____ ☐ Asian (**please specify**) _____

☐ Native Hawaiian or Pacific Islander (**please specify**) _____

2. Household Members: *Please list everyone living in the household who may be counted in family size,*

for families temporarily living with relatives or others, do not list the hosts.

For families with two households when there is joint custody with no primary parent and no child support

- *Enter the household members for both households in the graph below.*
- *Mark members of the second household.*
- *Then answer the questions about financial support and relationships.*

(Staff will use this information to calculate family size to determine federal poverty level.)

First Name		Last Name	Birth date	Relationship to enrolled child	Does this parent financially support this child?	Is this person related to the enrolling child's parent/guardian by blood, marriage, or adoption?
Enrolled Child				Enrolled Child	yes	yes
Parent/guardian					yes	yes
Parent/guardian					yes	yes

**Answer No for a person age 19 or older who has earned or unearned income that covers more than half of their expenses. Answer Yes if the enrolled child's parents pay more than half of their expenses.

Family size verified by viewing:

☐ Benefits letter (TANF, SSI, etc.)
☐ Tax records from previous year (1040)
☐ Provider One health insurance
☐ School Records
☐ Other _____
☐ Foster care grant (for child-only application)
☐ Rental/housing document
☐ Signed application or parent statement
☐ Court or Legal Document

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? _____

Parent/guardian #1 Name_____ Phone # _____

Email (*Please write clearly*) _____

Street Address _____ City _____ Zip_____

Mailing address (if different) _____ City _____ Zip_____

Parent/guardian #2 Name_____ Phone # _____

Email (*Please write clearly*) _____

Street Address _____ City _____ Zip_____

Mailing address (if different) _____ City _____ Zip_____

Child lives with:

☐ One parent/guardian Name_____ (**Skip to Section 4**)

☐ Two parents/guardians in same household Names _____ **(Skip to Section 4**)

☐ 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, 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
- ☐ Passport or Visa
- ☐ Other _____

4. Parent Employment Training, and other Activities:

Answer the following questions for each parent/guardian *(Do not count the same hours in more than one category)*	Parent/Guardian #1 **Name** _____	Parent/Guardian #2 **Name** _____
Is this parent/guardian employed?	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, average number of paid hours per week		
b. If yes, enter employer name		
c. If yes, enter employer phone or email.		
In school or job training?	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, enter class hours per week		
b. If yes, study hours per week (maximum 10 hrs.)		
c. If yes, enter name of school or training organization		
d. If yes, enter goal or major.		
Travel between child care and work/school	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, hours per week (maximum 10)		
CPS/FAR/ICW child care hours not counted above	☐ Yes ☐ No	☐ Yes ☐ No
a. Additional hours per week of child care approved by CPS		
Approved Work First hours not counted above	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, name of activity.		
b. If yes, total hours per week		
Disabled parent unable to work and unable to care for the child while the other parent work.	☐ Yes ☐ No	☐ Yes ☐ No
If either parent has more than 55 hours total per week explain.		

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

☐ DCYF Website ☐ Community Event ☐ Flyer ☐ ECEAP Employee ☐ Word of Mouth ☐ Media

☐ Caseworker ☐ Community Agency (*Name of Agency*): _____

☐ Other (*Describe*):_____

6. 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.

☐ School Day – about six hours four or five days a week.

☐ Working Day – available all day, all year, like a child care center.

7. 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

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

For children in foster or kinship care or adapted after foster or kinship care, fill in this box if applicable and then skip to (Section 9).	**Staff verified income by viewing:**
Monthly grant or payment for foster care, kinship care or adoption support: $_____ # of children on grant or payment _____ Case # or Client ID # if any: _____ Payment Source (circle): 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 for no income and explain how basic needs are met:
  _____
- Enter all family income for one year in the chart below.
  Select one: ☐ Previous calendar year ☐ Previous 12 months

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

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

Do you still receive the income above? ☐ Yes ☐ No ***If yes, skip to (section 9)***

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

☐ Divorce or separation ☐ Unplanned job Loss ☐ Loss of wage earned

☐ Reduced work hours ☐ Health/Injury

☐ Loss of benefits ☐ unexpected circumstance (explain) _____

What is your monthly income: $_____ For which month? _____

9. Previous Enrollment

Was this child previously enrolled in Head Start in Pullman ☐ Yes ☐ No

Was this child previously enrolled in Head Start with a different agency ☐ Yes ☐ No

Was this child enrolled in Early Head Start? ☐ Yes ☐ No (Name of Early Head Start Grantee) _____

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

Migrant/Seasonal Head Start anywhere in Washington ☐ Yes ☐ No

Part CIDEA Early Intervention program in another state ☐ Yes ☐ No (Name of State and Provider)_____

10. IEP or Suspected Delay

- ☐ This child has an Individualized Education Program (IEP)?
- ☐ This child has a diagnosed developmental delay or disability with no IEP.
- ☐ This child completed a developmental screening that recommended referral for further evaluation.
- ☐ This child has a suspected developmental delay or disability. (No IEP, diagnosis, or screening, or completed developmental/screening with result, "rescreen needed".) *Please Describe:*

  _____

If this child has an IEP check all categories of the IEP. If not, skip to question 11.

☐ 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		

IEP Start Date: _____ IEP End Date: _____

What school district issued this child's IEP? _____

This child will receive IEP services:

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

11. Has this child been expelled from any early learning program or child care due to behavior? ☐ Yes ☐ No

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

12. Additional Questions

We use this information below to prioritize the children who need the program the most.

All responses are kept confidential.

Does this child have a household family member who has a chronic physical or mental health condition?
- Severely impacts their ability to engage in work, school, or family life? ☐ Yes ☐ No
- Moderately impacts their ability to engage in work, school, or family life? ☐ 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 or seasonal agricultural worker? (51% or more of family income from agricultural work) ☐ 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 military parent deployed currently, or within the past 12 months, or for over 19 months within the child's life time? ☐ Yes ☐ No

Does this child have a parent who is incarcerated in jail, prison or a detention center? ☐ Yes ☐ No

Has this child experienced the loss of a parent, such as by death, abandonment, or deportation? ☐ Yes ☐ No

Has this child experienced the divorce of separation of their parents? ☐ Yes ☐ No

Has this child experienced homeless within the last 12 months? ☐ Yes ☐ No

Has this child lived in a household with domestic violence including in-utero? ☐ Yes ☐ No

Has this child lived in a household with substance abuse including in-utero? ☐ Yes ☐ No

Has this child family received CPS/FAR/ICW services or been involved with law enforcement/court system regarding child abuse, neglect, or sexual assault in the past? ☐ Yes ☐ No

Has this child been reunited with parent after foster or kinship care in the past 12 months? ☐ Yes ☐ No

The program received a professional referral for this child ☐ Yes ☐ No
If yes, name of referring agency: _____

Is the mother pregnant or has there been a newborn in the past 12 months? ☐ Yes ☐ No

13. Parent Information: Check (√) each parent's highest level of education and part time or full-time school/employment. (√)

	Employment	Employed full-time	Employed part-time	Unemployed	**Education**	In educational program full-time	In educational program part-time	6th 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 _____															

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

Does this child have a chronic physical or mental health condition that:

Severely impacts child development or attendance? ☐ Yes ☐ No

Moderately impacts child development or attendance? ☐ Yes ☐ No

If yes, please describe _____

Was this child born preterm (less than 37 week), or weighed 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 Dentist: _____

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 promise that the information on this application is accurate and truthful to the best of my knowledge. I have reported all my income and family size as required by the program. I am aware that, if I knowingly provide false information, my child could be disqualified from the program. Additionally, I may have to repay the amount spent on my child. I give permission for the program to share my information with other state agencies, research firm and internal databases for the purposes of data reporting and providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of participant information. No information related to immigration status is entered in any data base or shared with any state or federal agencies.

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. I understand that I am required to notify DCYF or Head Start if I suspect any fraudulent use of programs funds. Any intentional attempt by staff to enroll families who are not eligible into the program will result in termination of employment.

Staff: Print name _____ ***Signature*** _____ ***Date*** _____