



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 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, 2019. However, children who turn three years old after this date will be considered for Head Start.

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 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 2018 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

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.



COMMUNITY CHILD CARE CENTER

530 NW Greyhound Way Pullman, WA. 99163 (509) 334-9290

Head Start/EHS/ECEAP/Child Care

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

Child's birth date ____/____/____ Gender: M__ F__

Legal First Name _____ Middle Name _____ Legal Last Name _____

IEP - 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

CPS - Is this child's family currently receiving Child Protective Services (CPS), Family Assessment Response (FAR) services, or similar Indian Child Welfare (ICW) services? Yes No

Foster Care - Is this child in official foster care? Yes No

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

Was this child adopted after foster or kinship care? 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

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 _____

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

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

by the parent's income of the enrolled child. 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.

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

	First Name	Last Name	Relationship to enrolled child	Birth date
1.Enrolled Child			Enrolled Child	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

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 _____ Email _____

Street Address _____ City _____ Zip _____ Phone _____

4. 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 other: _____

5. 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.

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 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

7. Child lives with:

One parent/guardian Name _____ **(Skip to Section 8)**

Two parents/guardians in same household Names _____ **(Skip to Section 8)**

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 8)**

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 8)**

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 _____

8. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, average paid hours per week		
b. If yes, enter employer name		
c. If yes, enter employer phone or email.		
In school or job training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, hours per week (maximum 10)		
CPS/FAR/ICW child care hours not counted above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Additional hours per week of child care approved by CPS		
Approved Work First hours not counted above	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If either parent has more than 55 hours total per week explain.		

9. 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 (Section10).

Monthly grant or payment for foster care, kinship care or adoption support: \$ _____
 # of children on grant _____ Case # or Client ID # if any: _____
 Payment Source (circle): DSHS SSI TRIBE OTHER

Staff verified income by viewing:

- 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 one: 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) 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 10)*

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? _____

Staff verified monthly income by viewing:

Note: You must also verify annual income.

10. 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

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

11. 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.

- 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? _____

12. 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.

- 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
- Is this family socially-isolated, with complete or near complete lack of contact with others? Yes No
- The program received a professional referral for this child Yes No
If yes, name of referring agency: _____
- 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

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

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

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

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 certify that the information on this form is true and correct. I have reported all my income and family size as required by the program. I understand 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 understand that this information may be reported to other state agencies or research firms. No information related to immigration status is entered in any data or shared with 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.

Print name _____ *Signature* _____ *Date* _____