Early Learning Application 2020-21

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Welcome! Please complete one application packet per child and attach the required documents.

Eligibility to our programs is determined by child's age and family income, not by the date you applied.

Our programs fill up fast, so please apply as soon as you can!

The information on your application is confidential and used only to determine your child's eligibility for our Early Learning Programs.

We do not require, check, or report on immigration or DSHS status.

REQUIRED DOCUMENTS

Please contact us if you need help to complete the application or if you do not have any of the required documents listed below.

1

Application: Fill out the application form using a black or blue pen.

2

Proof of Income: Attach a copy of your proof of family income.

Use any that apply:

- Last year's Income Tax Return
- Last year's W-2 Form
- Pay stubs from the last 12 months
- SSI/TANF benefits letters from the last 12 months
- Foster care grant
- Child support
- Employer letter stating your total gross income from the last 12 months

3

Proof of Family Size: Attach a copy of proof of family size.

Use any of these:

- Last year's Income Tax Return
- Rental or housing document
- Benefits letter (TANF, SSI, etc.)
- School records
- Court or legal document

4

Proof of Child's Age: Attach a copy of your child's proof of birth date.

Use any of these:

- Birth Certificate
- Passport/Visa
- Adoption Papers
- Foster Care Authorization Letter
- Current Immunization Record
- DOC residential parenting roster

5

Proof of Legal Guardianship: Attach a copy of your proof of legal guardianship.

Use any of these:

- Birth Certificate
- Passport/Visa
- Adoption Papers
- Foster Care Record
- Written agreement signed and dated by parent and person assuming custodial responsibility

- **Please make sure that your proof of income is included. We cannot process your application without this information.**
- **Call our office if you receive other types of documents, not listed above.**
- **It would be helpful to also include the following:**
  1. **A copy of your child's current immunization record**
  2. **Current IFSP/IEP, if applicable**
  3. **Most recent well-child exam**
  4. **Most recent dental exam**

Return your completed application and documents to:

Address:
Meadow Crest Early Learning Center
1800 Index Ave NE
Renton, WA 98056

Phone Number: (425) 204-2500
MeadowCrest.Headstart.ECEAP@rentonschools.us
Fax: (425) 204-2533

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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

What is this child's 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:

What is your family's heritage/tribe/country of origin?

Has this child previously attended these programs? Only check the **most recent:**

☐None
☐ Early Support for Infants and Toddlers (ESIT) or any Birth-to-Three/Home Visiting program
☐Head Start/Early Head Start/ECEAP in King or Pierce County, Washington State
☐Head Start/Early Head Start/ECEAP in another Washington State County
☐Migrant/Seasonal Head Start anywhere in Washington State

When did this child last attend?

Name and location of program:

Is this child currently enrolled in a community slot at this site? ☐Yes ☐No

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? ☐Yes ☐No

Does your family currently receive services through Child Protective Services (CPS), Family Assessment Response (FAR), or Indian Child Welfare (ICW)? ☐Yes ☐No

Has your family received services from CPS/FAR/ICW in the past? ☐Yes ☐No

Is your family currently approved for child care 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

What is your child's immunization status? ☐Fully immunized ☐Exempt ☐Not fully immunized or exempt ☐Not sure

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 dental exam within the last 6 months?
☐Yes – Date of last exam (month/day/year):
☐No ☐Date Unknown

Has this child been diagnosed by a Health Care Provider with a chronic health condition (may include 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 ☐Mild
☐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.) ☐Preterm birth less than 37 weeks ☐Drug/alcohol affected
☐Hearing ☐Fine motor/gross motor ☐Tooth pain/decay/bleeding gums
☐Vision ☐Food intolerance/special diet –
Please describe:

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

☐No – Check if any of these apply:
☐My child has a diagnosed developmental delay or disability, has no IEP, **or** is being referred for evaluation.
☐My child has a suspected developmental delay or disability.

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**
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)		
Address		
Phone	☐Home ☐Cell ☐Work	☐Home ☐Cell ☐Work
Alternate Phone	☐Home ☐Cell ☐Work	☐Home ☐Cell ☐Work
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 ☐7th to 12th grade, no diploma or GED ☐High school diploma ☐GED ☐Some college/advanced training ☐College/professional certificate ☐Associate degree ☐Bachelor's degree ☐Master's or doctorate degree ☐None	☐6th grade or less ☐7th to 12th grade, no diploma or GED ☐High school diploma ☐GED ☐Some college/advanced training ☐College/professional certificate ☐Associate degree ☐Bachelor's degree ☐Master's or doctorate degree ☐None

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	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, current service member ☐Yes, currently deployed or have been in the last 12 months/for a total of 19 months ☐Yes, veteran ☐No	☐Yes, current service member ☐Yes, currently deployed or have been in the last 12 months/for a total of 19 months ☐Yes, veteran ☐No

Family Concerns

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

☐Child's parent/guardian has a disability or is chronically ill and is:
- ☐Unable to engage in work/school/family life
- ☐Somewhat able to engage in work/school/ family life
- ☐Mostly able to engage in work/school/family life

☐Child's parent/guardian has learning difficulties, no disability

☐Household mental illness, including maternal depression (child is diagnosed, or adult is experiencing)

☐Household domestic violence (past or current)

☐Household drug/alcohol issues or substance abuse (past or current)

☐Family is socially isolated, with complete or near-complete lack of contact with others

☐Getting or keeping a job

☐Legal concerns

☐Child's parent/guardian is a migrant worker

☐Recent immigrant/refugee (past 5 years)

☐Child's parent/guardian is incarcerated

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

☐Child's parents/guardians divorced or separated during child's life

☐Previously homeless (in the last 12 months)

☐Concerns with housing

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:
- ➢ ☐ By choice (e.g. to save money, to be close to family, etc.)
- ➢ ☐ Due to loss of housing, economic hardship, or similar reason

☐ Other – Please describe:

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:

☐SSI for disability received by: ☐Child ☐Parent/Guardian ☐Other – Relationship to child:

☐Temporary Assistance for Needy Families (TANF) cash.

Check if you also have the following: ☐Child-only TANF ☐WorkFirst ☐Working Connections Child Care subsidy

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** of family members living in your home, including yourself and this child?

What is your **total estimated** household income for the last calendar year or the last 12 months?

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 Puget Sound Educational Service District (PSESD). DCYF and PSESD 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.

Parent/Guardian 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)

Staff Only			
Child's Age:	**Total Verified Family Size:**	**Total Verified Income:**	**Total Points:**
Site Name/ID:		**Date received:** (This date will determine eligibility timeframe)	
Date staff reviewed application with family:		**Date sent to PSESD (N/A for ECEAP only sites):**	

EHS Only - Is this child a newborn taking the mother's slot? ☐Yes ☐No **If yes, mother's name:** _____

For Homeless Families – Check the services that are needed or desired by the family and provide resources as soon as possible:

☐Child care resources	☐Immunization/medical records	☐Medicaid/DSHS services – Food stamps/TANF
☐Clothing resources	☐Vision referral	☐College/vocational/technical resources
☐School supplies	☐Hygiene products/toiletries	☐School transportation (if site provides)
☐Medical/dental referral	☐Food resources	☐Other: _____
☐Housing/shelter referral	☐Birth certificate	_____

Staff Name & Signature: _____ **Date:** _____