

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: Old Redmond SchoolHouse, FSS
16600 NE 80th Street
Redmond, WA 98052

Phone Number: (425) 936-1170 x2

Child Information – General

First Name:	Middle Initial:	Last Name:	Preferred Name:
Date of Birth (month/day/year):		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	

What is this child's home language?	2 nd language:
This child speaks: <input type="checkbox"/> Only English <input type="checkbox"/> Both English and another language the same (bilingual)	<input type="checkbox"/> Mostly English and another language <input type="checkbox"/> *Some English, but mostly another language <input type="checkbox"/> *Only a language other than English

Is this child Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is this child's race? Check all that apply. <input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian	<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above:
What is your family's heritage/tribe/country of origin?	
Is this child part of a tribe either by membership or by ancestry/lineage? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Has this child been previously enrolled in these programs? Only check the most recent . <input type="checkbox"/> None <input type="checkbox"/> Early Support for Infants and Toddlers (ESIT), IDEA Part C, ECLIPSE or any Birth-to-Three/Home Visiting program	<input type="checkbox"/> Head Start/Early Head Start/ECEAP/Early ECEAP in King or Pierce County, Washington State <input type="checkbox"/> Head Start/Early Head Start/ECEAP /Early ECEAP in another Washington State County	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this child a sibling of a child currently enrolled in the program you are applying to? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes , what is the Case Number or Client ID Number?	
What is the monthly grant/payment amount and source? \$	<input type="checkbox"/> DSHS <input type="checkbox"/> SSI <input type="checkbox"/> Tribe <input type="checkbox"/> Other
# of children covered by grant amount:	
Is this child in kinship care without a grant amount? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was this child adopted after foster care or kinship care or from orphanage from another country? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was this child recently reunited with their parent(s) after foster care or kinship care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your family currently receive services /support through Child Protective Services (CPS), Family Assessment Response (FAR), Indian Child Welfare (ICW), comparable tribal services, or law enforcement/court system? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your family received services/support from CPS/FAR/ICW, comparable tribal services, or law enforcement/court system in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your family currently approved for childcare through CPS or FAR? <input type="checkbox"/> Yes – How many approved hours per week? <input type="checkbox"/> No	
Has this child ever been asked to leave an early learning program because of behavior issues? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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

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

Does this child have a chronic health condition (may include mental health, 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 Has a Health Care Provider diagnosed this condition? Yes No

Child Information - Development

Do you have concerns about this child's health? Yes – check all that apply below No

<input type="checkbox"/> Low birth weight (less than 5.5 lbs/5 lbs 8 oz.)	<input type="checkbox"/> Preterm birth less than 37 weeks	<input type="checkbox"/> Drug/alcohol affected
<input type="checkbox"/> Hearing	<input type="checkbox"/> Fine motor/gross motor	<input type="checkbox"/> Tooth pain/decay/bleeding gums
<input type="checkbox"/> Vision	<input type="checkbox"/> 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	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other:	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other:
Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Not specified	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Not specified
Date of Birth (month/day/year)		
Address (include City, State, Zip)		
Phone	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Alternate Phone	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Email		
Were you under age 18 when this child was born?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
What language(s) do you speak?		
Do you need an interpreter for this language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your race? Check all that apply	<input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above:	<input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above:
What is the highest level of education you completed?	<input type="checkbox"/> 6 th grade or less <input type="checkbox"/> 7 th to 12 th grade, no diploma or GED <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's or doctorate degree <input type="checkbox"/> None	<input type="checkbox"/> 6 th grade or less <input type="checkbox"/> 7 th to 12 th grade, no diploma or GED <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's or doctorate degree <input type="checkbox"/> None



	Parent/Guardian 1	Parent/Guardian 2
Are you currently employed?	<input type="checkbox"/> Yes – How many hours per week (including travel)? Employer name & phone #: <input type="checkbox"/> No <input type="checkbox"/> No, retired or disabled <input type="checkbox"/> Seasonal	<input type="checkbox"/> Yes – How many hours per week (including travel)? Employer name & phone #: <input type="checkbox"/> No <input type="checkbox"/> No, retired or disabled <input type="checkbox"/> Seasonal
Are you currently in job training or school?	<input type="checkbox"/> Yes – How many hours per week (including class time, study time, travel)? School name & major/goal: <input type="checkbox"/> No	<input type="checkbox"/> Yes – How many hours per week (including class time, study time, travel)? School name & major/goal: <input type="checkbox"/> No
Are you in an approved WorkFirst activity?	<input type="checkbox"/> Yes – Describe the activity and the number of approved hours per week: <input type="checkbox"/> No	<input type="checkbox"/> Yes – Describe the activity and the number of approved hours per week: <input type="checkbox"/> No
Are you or have been in the U.S. military?	<input type="checkbox"/> Yes, current service member <input type="checkbox"/> Yes, currently deployed or have been in the last 12 months/for a total of 19 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No	<input type="checkbox"/> Yes, current service member <input type="checkbox"/> Yes, currently deployed or have been in the last 12 months/for a total of 19 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No

Family Concerns

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

<input type="checkbox"/> Household member has a disability or has a chronic physical or mental health condition and is:	<input type="checkbox"/> Family is socially isolated, with complete or near-complete lack of contact with others	<input type="checkbox"/> Recent immigrant/refugee (past 5 years)
<input type="checkbox"/> Unable to engage in work/school/family life	<input type="checkbox"/> Child's parent/guardian concern for getting or keeping a job	<input type="checkbox"/> Child's parent/guardian is incarcerated
<input type="checkbox"/> Somewhat able to engage in work/school/ family life	<input type="checkbox"/> Family has legal concerns	<input type="checkbox"/> Loss of a parent (death, abandonment, or deportation)
<input type="checkbox"/> Mostly able to engage in work/school/family life	<input type="checkbox"/> Child has a family member who attended Indian Boarding School	<input type="checkbox"/> Child's parents/guardians divorced or separated during child's life
<input type="checkbox"/> Child's parent/guardian has learning difficulties, no disability	<input type="checkbox"/> Child's parent/guardian is a migrant or seasonal worker with more than half of family income coming from agricultural work	<input type="checkbox"/> Family previously homeless (in the last 12 months)
<input type="checkbox"/> Household domestic violence (past or current), including <i>in utero</i>	<input type="checkbox"/> Parent and child moved to engage in traditional cultural practices or employment (seasonal or temporary in agricultural or fishing)	<input type="checkbox"/> Family concerns with housing
<input type="checkbox"/> Household drug/alcohol issues or substance abuse (past or current), including <i>in utero</i>		

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.**

Own In someone else's house or apartment with another family:
 Rent > By choice (e.g., to share responsibilities, to be close to family, etc.)
 > Due to loss of housing, economic hardship, or similar reason

 In a motel Transitional Housing
 In a shelter Moving from place to place/couch surfing
 A car, park, campsite, or similar location In a residence with inadequate facilities (no water, heat, electricity)

 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 SNAP

Check all that apply if your family receives the following:

Child-only TANF WorkFirst Working Connections Child Care subsidy WIC

Were you referred to this program by an agency? Yes - Name: _____ No

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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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)

PSESD Early Learning Staff Only			
Section 1: Staff who finalize and determine eligibility complete this section before placing in the Master Waitlist Drawer			
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 family's slot? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, family's name: _____			
Section 2: For McKinney-Vento Act children/families. Check services the family received. Staff should provide resources within 24-48 hours.			
<input type="checkbox"/> Childcare resources	<input type="checkbox"/> Immunization/medical records	<input type="checkbox"/> Medicaid/DSHS services – Food stamps/TANF	
<input type="checkbox"/> Clothing resources	<input type="checkbox"/> Vision referral	<input type="checkbox"/> College/vocational/technical resources	
<input type="checkbox"/> School supplies	<input type="checkbox"/> Hygiene products/toiletries	<input type="checkbox"/> School transportation (if site provides)	
<input type="checkbox"/> Medical/dental referral	<input type="checkbox"/> Food resources	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Housing/shelter referral	<input type="checkbox"/> Birth certificate		
Staff Name & Signature: _____			Date: _____