Early Learning Application 2023-2024

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

Staff Only - ChildPlus ID: **ELMS ID:**

Child Information – General

First Name:	Middle Initial:	Last Name:
Preferred Name:		Date of Birth (month/day/year):
Gender: ☐ M ☐ F ☐ Trans girl ☐ Trans boy	Gender Identity (optional):	Preferred Pronouns (optional):

What is this child's home language? 2nd language:

This child speaks: ☐ 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?

Is this child part of a tribe either by membership or by ancestry/lineage? ☐ Yes ☐ No

Has this child been previously enrolled in these programs? Only check the **most recent**.

☐ None
☐ Early Support for Infants and Toddlers (ESIT), IDEA Part C, ECLIPSE, or Birth-to-Three Early Intervention
☐ Head Start/Early Head Start/ECEAP/Early ECEAP in King or Pierce County, Washington State
☐ Head Start/Early Head Start/ECEAP /Early 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 child currently enrolled in the program you are applying to? ☐ 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 or from orphanage from another country? ☐ Yes ☐ No

Was this child recently reunited with their parent(s) after foster care or kinship care? ☐ Yes ☐ 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? ☐ Yes ☐ No

Has your family received services/support from CPS/FAR/ICW, comparable tribal services, or law enforcement/court system in the past? ☐Yes ☐No

Child's First Name:	Child's Last Name:

Is your family currently approved for childcare 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

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

☐ Low birth weight (less than 5.5 lbs/5 lbs 8 oz.)
☐ Hearing
☐ Vision
☐ Preterm birth less than 37 weeks
☐ Fine motor/gross motor
☐ Food intolerance/special diet – Please describe:
☐ Drug/alcohol affected
☐ Tooth pain/decay/bleeding gums

Does this child have a **current and active** Individual Education Plan (IEP) or Individual Family Service Program (IFSP)?

☐ Yes – Please provide a copy with your application.

☐ No – Check if any of these apply:

- ☐ My child has qualified for Part B special education services but does not have a written IEP.
- ☐ My child has had an IFSP in the past but did not transition to an IEP with the school district.
- ☐ My child has a diagnosed developmental delay or disability with no IEP, **or** is being referred for evaluation.
- ☐ My child has a suspected developmental delay or disability.
- ☐ I have concerns about my child's development.

Child's First Name:	Child's Last Name:

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 ☐ Trans woman ☐ Trans man	☐ M ☐ F ☐ Trans woman ☐ Trans man
Gender Identity (optional)		
Preferred Pronouns (optional)		
Date of Birth (month/day/year)		
Address (include City, State, Zip)		
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
Are you Hispanic/Latino?	☐ 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

Child's First Name:	Child's Last Name:

	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.

☐ Household member has a disability **or** has a chronic physical or mental health condition **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 domestic violence (past or current), including *in utero*

☐ Household drug/alcohol issues or substance abuse (past or current), including *in utero*

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

☐ Child's parent/guardian concern for getting or keeping a job

☐ Family has legal concerns

☐ Child has a family member who attended Indian Boarding School

☐ Child's parent/guardian is a migrant or seasonal worker with more than half of family income coming from agricultural work

☐ Parent and child moved to engage in traditional cultural practices or employment (seasonal or temporary in agricultural or fishing)

☐ 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

☐ Family previously homeless (in the last 12 months)

☐ Family concerns with housing

Child's First Name: **Child's Last Name:**

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
☐ Rent
☐ Military – waiting for permanent housing
☐ In someone else's house or apartment with another family (select one option below):
- ☐ 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
☐ In a shelter
☐ A car, park, campsite, or similar location
☐ Transitional Housing
☐ Moving from place to place/couch surfing
☐ 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 all people living in this child's primary household.

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?

Child's First Name:	Child's Last Name:

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)	

EHS Only - Is this a newborn taking a pregnancy slot? ☐ Yes ☐ No If yes, pregnant participant's name:

Section 2: For McKinney-Vento Act children/families. Check services the family received. Staff should provide resources within 24-48 hours.

☐ Childcare 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:**