

Olympic Community Action Programs

Early Childhood Services

Thank you for your interest in enrolling your child in Head Start/Early Head Start/ECEAP.

In order to process your application we must have the following:

1. **Proof of income for 12 months.** This can be the first page of your most recent tax return which shows your gross income, W-2 or most recent pay stub with Year-to-Date income, TANF or SSI letter, or letter from employer. If you do not have these, please contact us for more instruction.
2. **Proof of birth.** A state or hospital birth certificate (copy) or other legal document such as a passport.

Please be sure to fully complete the **Special Considerations/Priority for Enrollment** section on the front of the application that apply to your family. The program does not enroll on a first come, first served basis but is required to ensure those children and families with the greatest need get the first opportunity.

The application must have a **signature and date** on the 2nd page.

It is important that we have a reliable way to contact you. Write clearly, include phone numbers and e-mail address. If you can only receive a text message please let us know.

For families of children with diagnosed **special needs**, please include a copy of their **Current IEP or IFSP**. This ensures they receive the appropriate placement on our wait lists for service.

Return the completed, signed application to:

Dina Rae Geiszler/Family Service Coordinator
OlyCAP
228 W 1st Street Suite J
Port Angeles, WA 98362
(360) 452-4726 Ext. 6223
dgeiszler@olycap.org

2018-19 ECEAP Prescreen & Application (Combined form)

Return to: OlyCap/ECS, 228 W. 1st Street, Suite J., Port Angeles, WA 98362

1. Child Information

School year applying for: _____

Legal First Name _____ Middle Name _____ Legal Last Name _____

Child's birth date ____/____/____ Nickname _____ Gender _____

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

Is this child in official foster care? *This means there is a caregiver authorization from a state or tribe that says this is a foster care placement.* Yes No

Is this child's family currently receiving Child Protective Services (CPS) or similar Indian Child Welfare (ICW) services? Yes No

Is this child's family currently receiving Family Assessment Response (FAR)? Yes No

Is this child homeless? *This means no fixed, regular, and adequate nighttime residence.* Yes No
 If yes, does this child live with a parent or consistent guardian? Yes No

Is this child living with a guardian, who is not their parent or foster parent, who receives a state, tribal, or SSI payment on behalf of the child? Yes No

This child speaks (select only one):
 Only English
 Mostly English, and some of another home language
 Some English, but mostly another home 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, check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Argentinian | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Salvadoran |
| <input type="checkbox"/> Bolivian | <input type="checkbox"/> Honduran | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Chilean | <input type="checkbox"/> Mexican or Mexican-American (Chicano) | <input type="checkbox"/> Uruguayan |
| <input type="checkbox"/> Colombian | <input type="checkbox"/> Nicaraguan | <input type="checkbox"/> Venezuelan |
| <input type="checkbox"/> Costa Rican | <input type="checkbox"/> Panamanian | <input type="checkbox"/> Latin American |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Peruvian | <input type="checkbox"/> Other Hispanic or Latino (describe)_____ |
| <input type="checkbox"/> Dominican | <input type="checkbox"/> Puerto Rican | |
| <input type="checkbox"/> Ecuatorian (Ecuadorian) | | |

What race(s) do you consider this child? (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Quinault | <input type="checkbox"/> Maldivian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Samish | <input type="checkbox"/> Mongolian |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Sauk-Suiattle | <input type="checkbox"/> Nepali |
| <input type="checkbox"/> Aleut (Unangan) | <input type="checkbox"/> Shoalwater | <input type="checkbox"/> Pakistani |
| <input type="checkbox"/> Alutiiq | <input type="checkbox"/> Skokomish | <input type="checkbox"/> Singaporean |
| <input type="checkbox"/> Athabaskan | <input type="checkbox"/> Snohomish | <input type="checkbox"/> Sri Lankan |
| <input type="checkbox"/> Eskimo (Inupiaq or Yupik) | <input type="checkbox"/> Snoqualmie | <input type="checkbox"/> Taiwanese |
| <input type="checkbox"/> Eyak | <input type="checkbox"/> Snoqualmoo | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Haida | <input type="checkbox"/> Spokane | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Tlingit | <input type="checkbox"/> Squaxin Island | <input type="checkbox"/> Other Asian (describe)_____ |
| <input type="checkbox"/> Tsimshian | <input type="checkbox"/> Steilacoom | |
| <input type="checkbox"/> Other Alaska Native (describe)_____ | <input type="checkbox"/> Stillaguamish | |
| | <input type="checkbox"/> Suquamish | |
| | <input type="checkbox"/> Swinomish | |
| | <input type="checkbox"/> Tulalip | |
| | <input type="checkbox"/> Upper Skagit | |
| | <input type="checkbox"/> Yakama | |
| | <input type="checkbox"/> Other American Indian (describe)_____ | |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Chehalis | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Fijian |
| <input type="checkbox"/> Chinook | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Guamanian |
| <input type="checkbox"/> Colville | <input type="checkbox"/> Bhutanese | <input type="checkbox"/> Kosraean |
| <input type="checkbox"/> Cowlitz | <input type="checkbox"/> Burmese | <input type="checkbox"/> Mariana Islander |
| <input type="checkbox"/> Duwamish | <input type="checkbox"/> Cambodian/Kampuchean | <input type="checkbox"/> Marshall Islander |
| <input type="checkbox"/> Hoh | <input type="checkbox"/> Chinese | <input type="checkbox"/> Melanesian |
| <input type="checkbox"/> Jamestown | <input type="checkbox"/> Filipino | <input type="checkbox"/> Micronesian |
| <input type="checkbox"/> Kalispel | <input type="checkbox"/> Hmong | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Kikiallus | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Palauan |
| <input type="checkbox"/> Lower Elwha | <input type="checkbox"/> Japanese | <input type="checkbox"/> Papua New Guinean |
| <input type="checkbox"/> Lummi | <input type="checkbox"/> Korean | <input type="checkbox"/> Ponapean (Pohnpeian) |
| <input type="checkbox"/> Makah | <input type="checkbox"/> Laotian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Muckleshoot | <input type="checkbox"/> Madagascar | <input type="checkbox"/> Solomon Islander |
| <input type="checkbox"/> Nisqually | <input type="checkbox"/> Malayan | <input type="checkbox"/> Tahitian |
| <input type="checkbox"/> Nooksack | | <input type="checkbox"/> Tarawa Islander |
| <input type="checkbox"/> Port Gamble Klallam | | <input type="checkbox"/> Tokelauan |
| <input type="checkbox"/> Puyallup | | <input type="checkbox"/> Tongan |
| <input type="checkbox"/> Quileute | | <input type="checkbox"/> Trukese (Chuukese) |
| | | <input type="checkbox"/> Vanuatuan/New Hebrides |
| | | <input type="checkbox"/> Yapese |
| | | <input type="checkbox"/> Other Pacific Islander (describe)_____ |

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.

				<i>Skip these two questions if ECEAP child is in foster care or living with a guardian who receives a payment for care.</i>	
First Name	Last Name	Birthdate	Relationship to ECEAP Child	Does the ECEAP child's parent or guardian financially support this person? <i>* See note below for people age 19 or older.</i>	Is this person related to the ECEAP child's parent/guardian by blood, marriage, or adoption?
ECEAP Child:			ECEAP Child	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 ECEAP child's parents pay more than half of expenses.

For staff use only:
 Family size for FPL chart _____
 For children in foster care or kinship care with a payment, count family size as 1.
 For all others, count people with Yes for both questions above.

3. Family Contact Information

Do you need an interpreter to communicate with English speakers? Yes No

If yes, what language(s) do you speak? _____

Physical Street Address _____ Apt # _____ City _____ Zip _____

Mailing Address (if different) _____ City _____ Zip _____

Email _____

Phone _____ Alternate Phone _____

4. Child lives with:

One parent/guardian (Name) _____ *Skip to section 5.*

Two parents/guardians in same household (Names) _____
_____ *Skip to section 5.*

Two parents/guardians in two households
If this is checked, answer these questions to determine which parents' income is counted for ECEAP eligibility.

Does one household have primary legal custody? Yes No

If **yes**, which parent has primary custody? _____
Spouse of this parent, if any: _____ *Skip to section 5.*

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 this parent, if any: _____ *Skip to section 5.*

If **no**, ECEAP will count the income from the legal parent/guardian for each household. Do not include their spouses. Enter the legal parents' names here:

Household 1 _____ Household 2 _____

Contact Info for Household 2:

Physical Street Address _____ Apt # _____ City _____ Zip _____

Mailing Address (if different) _____ City _____ Zip _____

Email _____

Phone _____ Alternate Phone _____

5. Parent Employment, Training, and Other Activities

Answer the following questions for each parent/guardian named in question #4	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, enter number of hours per week in paid work plus work-related travel.		
b. If yes, enter employer name and phone or email.		
Is this parent/guardian enrolled and attending school or job training ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, enter the total number of hours per week when school is in session. Include class time, up to 10 hours of study time, and travel time.		
b. If yes, enter name of school or training organization.		
c. If yes, enter goal or major.		
Is this parent/guardian in an approved WorkFirst activity other than employment, education or job training mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, describe activity.		
b. If yes, enter number of hours per week in approved activity and related travel.		
Is family approved for child care through CPS, FAR, or similar tribal funds ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, enter number of approved hours per week.		

6. How did you find out about ECEAP?

- DEL website Community event Flyer ECEAP employee Word of mouth
 Caseworker Media Community agency - Name of agency: _____
 Other - Describe other: _____

7. 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?
Please note, these options may not all be available in your community this year.

- Part Day – about three hours, three or four days a week.
 Full School Day – about six hours, four or five days a week.
 Extended Day – available all day, all year, like a child care center.

8. Household Situation

Does your household receive subsidized housing, such as a housing voucher or cash assistance for housing? Yes No
 Does your household currently receive a Working Connections child care subsidy for this child? Yes No

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

For children in foster or kinship care:

If this child is in foster care or living with a guardian who receives a payment for the child, fill in this box & skip to section 10.

Monthly grant or payment amount \$ _____ # of children covered by this grant amount _____

Case # or Client ID # _____ 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**, describe reason family does not have income: _____

Enter all family income for one year in the chart below.

Select either: Previous calendar year Previous 12 months

Person(s) with Income	Type	Weekly Amount	# of Weeks Received	Monthly Amount	# of Months Received	Annual Amount
	W-2					\$
	W-2					\$
	Tax return (1040) or IRS transcript					\$
	Tax return (1040) or IRS transcript					\$
	Pay stubs for 12 months					\$
	Pay stubs for 12 months					\$
	Child Support received, if required by a child support order			\$		\$
	Disability income, including SSI			\$		
	Military Leave & Earnings Statement (LES). Count all pay and allowances except BAH, BAS, FSH, and HFP/IDP.			\$		
	Self-employment net income					
	Social Security or other retirement benefits			\$		\$
	TANF cash assistance			\$		\$
	Child-only TANF or foster care grant for non-ECEAP child			\$		\$
	Unemployment	\$				\$
	Workers Compensation (L&I)	\$				
	Tribal income (taxable)					\$
	Other income not classified above			\$		\$
						\$
Subtract	Child support paid to another household, if required by a legally-binding child support order			\$		-\$
					TOTAL	\$

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
 Loss of job
 Job change
 Loss of wage earner
 Loss of benefits
 Other (explain) _____

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

10. Previous Enrollment

This child was previously enrolled in:

- | | |
|---|---|
| <input type="checkbox"/> Head Start at your agency | <input type="checkbox"/> Early Head Start |
| <input type="checkbox"/> Head Start with a different agency | <input type="checkbox"/> Any birth-to-three home visiting program |
| <input type="checkbox"/> Migrant/Seasonal Head Start anywhere in Washington | <input type="checkbox"/> ESIT - Early Support for Infants and Toddler |

11. IEP or Suspected Delay

- This child has an Individualized Education Program (IEP).
 This child has a suspected developmental delay or disability.

If this child has an IEP check all categories of the IEP. If not, skip to section 12.

- | | | |
|--|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Specific learning disability |
| <input type="checkbox"/> Deaf-blindness | <input type="checkbox"/> Multiple disabilities | <input type="checkbox"/> Speech or language impairment |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Orthopedic impairment | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Emotional disturbance | <input type="checkbox"/> Other health impairment | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Hearing impairment | | |

IEP Start Date _____ IEP End Date _____

What school district issued this child's IEP? _____

Is a school district special education preschool available for this child? Yes No

- 12.** Has this child been asked to leave a child care or preschool because of behavior issues? Yes No
ECEAP serves children with behavior issues. Checking yes will not exclude your child.

13. Additional Questions

We use this information to choose the children who most need ECEAP. All responses will be kept confidential.

- | | | |
|--|------------------------------|-----------------------------|
| Has this child been homeless within the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent who is developmentally or physically disabled? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent currently on active duty in the U.S. Military? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent currently a member of a National Guard unit or a Military Reserve unit? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent who is currently or was recently deployed to a combat zone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent who is incarcerated in jail, prison or a detention center? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent experiencing mental health issues (including maternal depression)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent who was under age 18 when this child was born? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child have a parent who is a migrant worker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has this child's family received services from Child Protective Services (CPS) or similar Indian Child Welfare (ICW) services in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has this child's family ever experienced domestic violence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this child's family struggle with substance abuse issues? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does this family have a support system outside of the household? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ECEAP received a professional referral for this family. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, which agency made the referral? _____

14. Parent Education Level: Check all that apply (v)

Highest level of education	Parent/Guardian 1 Name _____	Parent/Guardian 2 Name _____
6 th grade or less		
7 th to 12 th grade, no diploma or GED		
High school diploma or GED		
Some college		
Professional certificate (includes vocational schools)		
Associate degree		
Bachelor's degree		
Master's degree or doctorate		

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? Yes No Unknown
 Washington Apple Health for Kids/ Provider One Services Card
 Military Dental Coverage Private Dental Insurance
 Tribal Coverage

Does this child have a regular doctor or medical clinic? Yes No Unknown
 Name of clinic or provider _____
 Phone (optional) _____
 Name of medical professional _____

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 ECEAP ____ / ____ / ____
 Date Unknown

Does this child have dental insurance or coverage? Yes No Unknown
 Washington Apple Health for Kids/ Provider One Services Card
 Military Dental Coverage Private Dental Insurance
 ABCD (not available in all counties) Tribal Coverage

Does this child have a regular dentist or dental clinic?

Yes No Unknown

Name of clinic or provider _____

Phone (optional) _____

Name of dental professional _____

Did this child have a dental screening within the last 6 months?

Yes No Unknown

Date of last dental screening before applying for ECEAP ____ / ____ / ____

Date Unknown

Signature of Parent/Guardian

I certify that the information on this form is true and correct. I understand that, if I knowingly provide false information, my child could be disqualified from ECEAP and I may have to reimburse the amount spent on my child’s ECEAP services (\$780 or more per month).

I understand that information in this application may be combined with information about other ECEAP children and used for research studies, such as determining if participating in ECEAP helps children later in life. The identities of children and families would be removed before analyzing information for research.

I understand that information in this application may be reported to other state agencies. For example, individual child enrollment dates could be used to determine if state dollars spent on ECEAP may be used as “federal match” to allow Washington to receive more federal funds to serve families.

Print name _____

Signature _____

Date _____

Signature of ECEAP 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 ECEAP. I understand that ECEAP Performance Standards require that I notify the Department of Child, Youth, and Families (formerly Department of Early Learning) if I suspect any fraudulent use of ECEAP funds including, but not limited to, an employee intentionally entering deceptive or false information into ELMS regarding:

- o Child eligibility criteria.
- o Children’s actual start dates and last days in class.
- o Class start or end dates.
- o Services that were not actually provided.
- o A family providing false information in order to enroll in ECEAP.

Print name _____

Signature _____

Date _____