Washington State Department of CHILDREN, YOUTH & FAMILIES

# 2021-2022 ECEAP Application

***Use this form only if the ECEAP Prescreen was previously completed***

Childs Name: _____

Parent/Guardian Name: _____

## Section 1: 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.***

| First Name | Last Name | Birthdate | Relationship to ECEAP Child | Does the ECEAP child's parent or guardian financially support this person?* *See note below for people age 19 or older.* | 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 |
| Parent/guardian: | | | | Yes | Yes |
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**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 their expenses.*

**For staff use only**:

Family size for FPL chart _____

For children in foster care, kinship, or adopted after foster or kinship care, count family size as 1.

For all others, count people with Yes for both questions above.

## Section 2: 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

## Section 3: Income Received by Child's Parent(s) or Guardian(s)

For children in foster care, kinship care, or adopted after foster or kinship care, fill in this box and *skip to Section 4*

- Monthly grant or payment for foster care, kinship care, or adoption support $ _____
- Number of children covered by this grant or payment _____
- Case number or Client ID number, if any: _____
- Payment source (check): ☐ DSHS ☐ SSI ☐ Tribe ☐ Other _____

Did you receive income during the last calendar year or during the previous 12 months? ☐ Yes ☐ No

If no, provide the reason there is no income and explain how basic needs are met:

**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 | | | $ | | $ |
| | 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 | | | $ | | $ |

Do you still receive the income above? ☐ Yes ☐ No ***If yes, skip to section 4.***

If no, and your circumstances have recently changed, please explain:

_____

☐ Loss of wage earner ☐ Divorce or separation ☐ Unplanned job loss ☐ Reduced work hours
☐ Health/Injury ☐ Loss of benefits ☐ Similar unexpected circumstance (explain)

_____

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

## Section 4: Previous Enrollment

This child was previously enrolled in:

☐ Head Start at your agency
☐ Head Start with a different agency
☐ Migrant/Seasonal Head Start anywhere in WA
☐ Early Head Start
Name of EHS Grantee:
☐ Any birth to three home visiting program and toddler
☐ Early ECEAP
☐ ECLIPSE

☐ ESIT – Early Support or Infants
Name of ESIT Provider:

_____

☐ Part C IDEA Early Intervention program in another state
Name of state and provider:

_____

## Section 5: IEP or Suspected Delay

☐ This child has an Individualized Education Program (IEP)
☐ This child has a diagnosed developmental delay or disability with no IEP.
☐ This child completed a developmental screening that recommended referral for further evaluation
☐ This child has a suspected developmental delay or disability.
*(No IEP, diagnosis, or screening, or completed developmental screening with result, "rescreen needed".)*
*Please Describe :*

❖ *If this child has an IEP check all categories of the IEP. If not, skip to Section 6.*

☐ Autism
☐ Deaf-blindness
☐ Developmental delay
☐ Emotional disturbance
☐ Hearing impairment
☐ Intellectual disability
☐ Multiple disabilities
☐ Orthopedic impairment
☐ Other health impairment
☐ Specific learning disability
☐ Speech or language impairment
☐ Traumatic brain injury
☐ Visual impairment

IEP Start Date _____ IEP End Date _____
What school district issued this child's IEP? _____

This child will receive IEP Services:

☐ Within the ECEAP classroom only
☐ During ECEAP hours only, but outside the ECEAP classroom
☐ Outside ECEAP hours

## Section 6:

Has this child been expelled from any early learning program or child care due to behavior? ☐ Yes ☐ No

*ECEAP serves children with behavior issues.* ***Checking yes will not exclude your child.***

| **Section 7: Additional Questions** | | | | |
|---|---|---|---|---|
| *We use this information to choose the children who most need ECEAP. All responses will be kept confidential.* | | | | |
| Does this child have a household family member who has a chronic physical or mental health condition that:<br>• Severely impacts their ability to engage in work, school, or family life? | ☐ | Yes | ☐ | No |
| • Moderately impacts their ability to engage in work, school, or family life? | ☐ | 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:<br>• Is a migrant or seasonal agricultural worker? (*51% or more of family income from agricultural work)* | ☐ | Yes | ☐ | No |
| • Moves with child to engage in traditional cultural practices or employment *(seasonal or temporary in agricultural or fishing work)?* | ☐ | Yes | ☐ | No |
| Does this child have a parent currently on active duty in the U.S. Military? | ☐ | Yes | ☐ | No |
| Does this child have a parent currently a member of a National Guard or a Military Reserve Unit? | ☐ | Yes | ☐ | No |
| Does this child have a military parent deployed currently, or within the past 12 months, or for a total of 19 or more months within the child's lifetime? | ☐ | Yes | ☐ | No |
| Does this child have a family member who attended an Indian Boarding School? | ☐ | Yes | ☐ | No |
| Does this child have a parent who is incarcerated in jail, prison or a detention center? | ☐ | Yes | ☐ | No |
| Has this child experienced the loss of a parent, such as by death, abandonment, or deportation? | ☐ | Yes | ☐ | No |
| Has this child experienced the divorce or separation of their parents? | ☐ | Yes | ☐ | No |
| Has this child experienced homelessness within the last 12 months? | ☐ | Yes | ☐ | No |
| Has this child lived in a household with domestic violence, including in-utero? | ☐ | Yes | ☐ | No |
| Has this child lived in a household with substance abuse, including in-utero? | ☐ | Yes | ☐ | No |
| Has this family previously received support and/or been involved in tribal or state systems including CPS/FAR/ICW, or comparable tribal services, or been involved with law enforcement/court system regarding child abuse, neglect, or sexual assault? | ☐ | Yes | ☐ | No |
| Has this child been reunited with parents after foster or kinship care in the past 12 months? | ☐ | Yes | ☐ | No |
| ECEAP received a professional referral for this family. | ☐ | Yes | ☐ | No |
| If yes, which agency made the referral? | | | | |

## Section 8: Parent Education Level – Check all that apply

| Highest level of education | Parent/Guardian 1<br>Name _____ | Parent/Guardian 2<br>Name _____ |
|---|---|---|
| 6th grade or less | ☐ | ☐ |
| 7th to 12th 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 | ☐ | ☐ |

## Section 9: Health Information - *Please attach a copy of the child's immunization record*

Does this child have a chronic physical or mental health condition that: ☐ Yes ☐ No ☐ Unknown

- Severely impacts child development or attendance?
- Moderately impacts child development or attendance? ☐ Yes ☐ No ☐ Unknown
  - ❖ If yes, please describe:

Was this child born preterm (less than 37 weeks), or weigh less than 5.5 pounds at birth? ☐ Yes ☐ No ☐ Unknown

Does this child have medical insurance or coverage? ☐ Yes ☐ No ☐ Unknown

☐ Washington Apple Health for Kids/ Provider One Services Card

☐ Military Coverage ☐ Private Medical Insurance ☐ Tribal Coverage

Does this child have a regular doctor or medical clinic? ☐ Yes ☐ No ☐ Unknown

- Name of clinic or provider: _____ Phone: _____
- 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 Coverage ☐ Private Dental Insurance ☐ Tribal Coverage

☐ ABCD (not available in all counties)

Does this child have a regular doctor or dental clinic? ☐ Yes ☐ No ☐ Unknown

- Name of clinic or provider: _____ Phone: _____
- 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 promise that the information on this form is true and correct. I have reported all my income and family size, as required by ECEAP. If I knowingly provide false information, I understand my family may be unable to continue ECEAP services. Additionally, I may have to repay the amount spent on my child's ECEAP.

I understand that information from this application is entered in the Early Learning Management System (ELMS) operated by the Department of Children, Youth, and Families (DCYF). DCYF is committed to protecting confidential and personal information that could identify a child or family. No information related to immigration status is entered into ELMS or shared with state or federal agencies. Information in ELMS may be used for:

- Research studies to determine if participating in ECEAP 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.

Print Name _____

Signature _____ Date _____

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 Children, Youth, and Families 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:

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

Print Name _____

Title _____

Signature _____ Date _____