

## 2020-2021 ECEAP Prescreen & Application (Combined form)

Return to: \_\_\_\_\_

Legal First Name		Middle Name		Legal Last Name	
Child Date of Birth		Nick Name		Gender Identity	

**IEP** - Is this child on an Individualized Education Program (IEP)? ☐ Yes ☐ No

**CPS** - Is this child's family actively involved in Child Protective Services (CPS), Family Assessment Response (FAR), or Indian Child Welfare (ICW), or law enforcement/court system regarding child abuse, neglect, or sexual assault? ☐ Yes ☐ No

**Foster Care** - 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

**Kinship** - Is this child in kinship care with a relative or suitable other, with or without a grant? ☐ Yes ☐ No

**Adopted after foster/kinship care** - Was this child adopted after foster care, kinship care, or after living in an orphanage in another country (*This does not include other adoptions*)? ☐ Yes ☐ No

**Housing** (select one):

- ☐ Rent or own an adequate residence
- ☐ Doubled-up with another family for convenience, choosing to be close to family or friends, or choosing to save money for future plans
- ☐ Doubled-up with another family due to loss of housing, economic hardship, or a similar reason
- ☐ In an emergency or transitional shelter
- ☐ Sleeping in a hotel, motel, car, park, campsite, or similar location
- ☐ Moving from place to place (couch surfing)
- ☐ Inadequate housing such as no water, heat or electricity; excessive mold; or no cooking facilities

**Language** 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	
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**Is this child Hispanic/Latino?** ☐ Yes ☐ No

*If yes, check all that apply:*

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

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

☐ **White**

☐ **Black or African American**

☐ **Alaska Native**

- ☐ Aleut (Unangan)
- ☐ Alutiiq
- ☐ Athabaskan
- ☐ Eskimo (Inupiaq or Yupik)
- ☐ Eyak
- ☐ Haida
- ☐ Tlingit
- ☐ Tsimshian
- ☐ Other Alaska Native (describe)

☐ **American Indian**

- ☐ Chehalis
- ☐ Chinook
- ☐ Colville
- ☐ Cowitz
- ☐ Duwamish
- ☐ Hoh
- ☐ Jamestown
- ☐ Kalispel
- ☐ Kikiallus
- ☐ Lower Elwha
- ☐ Lummi
- ☐ Makah
- ☐ Muckleshoot
- ☐ Nisqually
- ☐ Nooksack
- ☐ Port Gamble Klallam
- ☐ Puyallup
- ☐ Quileute

- ☐ Quinault
- ☐ Samish
- ☐ Sauk-Suiattle
- ☐ Shoalwater
- ☐ Skokomish
- ☐ Snohomish
- ☐ Snoqualmie
- ☐ Snoqualmoo
- ☐ Spokane
- ☐ Squaxin Island
- ☐ Steilacoom
- ☐ Stillaguamish
- ☐ Suquamish
- ☐ Swinomish
- ☐ Tulalip
- ☐ Upper Skagit
- ☐ Yakama
- ☐ Other American Indian (describe)

☐ **Asian**

- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Bhutanese
- ☐ Burmese
- ☐ Cambodian/Kampuchean
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Madagascar
- ☐ Malayan

- ☐ Maldivian
- ☐ Mongolian
- ☐ Nepali
- ☐ Pakistani
- ☐ Singaporean
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other Asian (describe)

☐ **Native Hawaiian or Other Pacific Islander**

- ☐ Fijian
- ☐ Guamanian
- ☐ Kosraean
- ☐ Mariana Islander
- ☐ Marshall Islander
- ☐ Melanesian
- ☐ Micronesian
- ☐ Native Hawaiian
- ☐ Palauan
- ☐ Papua New Guinean
- ☐ Ponapean (Pohnpeian)
- ☐ Samoan
- ☐ Solomon Islander
- ☐ Tahitian
- ☐ Tarawa Islander
- ☐ Tokelauan
- ☐ Tongan
- ☐ Trukese (Chuukese)
- ☐ Vanuatuan/New Hebrides
- ☐ Yapese
- ☐ Other Pacific Islander (describe)

## 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

\*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.

## Family Contact Information

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

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

Physical Address \_\_\_\_\_ Apt Number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
ZIP \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

### 2. 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 Household 1

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

#### Contact Household 2

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

### 3. Parent Employment, Training, and Other Activities

Answer the following questions for each parent/guardian listed in question #4.

Do not count the same hours in more than one category. For example:

- Do not count the same hours of the week in both employment and WorkFirst.
- Do not count the same CPS child care hours separately for two parents.

	Parent/Guardian #1 Name _____	Parent/Guardian #2 Name _____
<b>Employed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, average paid hours per week		
b. If yes, enter employer name (don't enter unknown or N/A)		
c. If yes, enter employer phone number or email		
<b>In school or job training?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, class hours per week		
b. If yes, study hours per week (maximum 10)		
c. If yes, enter name of school or training organization.		
d. If yes, enter goal or major.		
<b>Travel between child care and work/school?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, hours per week (maximum 10)		
<b>CPS/FAR/ICW child care hours not counted above?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Additional hours per week of child care approved by CPS		
<b>Approved WorkFirst hours not counted above?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, name of activity.		
b. If yes, total hours per week		
<b>Disabled parent</b> unable to work and unable to care for the child while the other parent works?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If either parent has more than 55 hours total per week, explain:</b>		

#### 4. How did you find out about ECEAP?

- ☐ DCYF website ☐ Community event ☐ Flyer ☐ ECEAP employee ☐ Word of mouth  
☐ Caseworker ☐ Media ☐ Community agency - Name of agency: \_\_\_\_\_  
☐ Other - Describe other: \_\_\_\_\_

#### 5. 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.  
☐ School Day – about six hours, four or five days a week.  
☐ Working Day – available all day, all year, like a child care center.

#### 6. 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

#### 7. 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 10**

**Monthly** grant or payment for foster care, kinship care, or adoption support \$ \_\_\_\_\_

# of children covered by this grant or payment \_\_\_\_\_

Case # or Client ID#, if any: \_\_\_\_\_ 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, 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					
	Paystubs for 12 months					
	Paystubs 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					
<b>Subtract</b>	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 10.*

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? \_\_\_\_\_

## 8. 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 Washington  
☐ Early Head Start

Name of EHS Grantee \_\_\_\_\_

☐ Any birth-to-three home visiting program

☐ ESIT - Early Support for Infants

Name of ESIT Provider \_\_\_\_\_

☐ Part C IDEA Early Intervention program in another state

Name of state and provider \_\_\_\_\_

and Toddler

## 9. 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 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    |  |  |

Name of ESIT Provider \_\_\_\_\_ State of ESIT Provider \_\_\_\_\_

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

**10.** Has this child been expelled from any early learning program or child care due to behavior?  
*ECEAP serves children with behavior issues. Checking yes will not exclude your child.*

☐ Yes ☐ No

## 11. 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:

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 is a migrant or seasonal agricultural worker? (51% or more of family income from agricultural 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 unit 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 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 received CPS/FAR/ICW services or been involved with law enforcement/court system regarding child abuse, neglect, or sexual assault in the past?? ☐ 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? \_\_\_\_\_

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

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

## 13. Health Information *Please attach a copy of the child's immunization record*

Does this child have a chronic physical or mental health condition that:

Severely impacts child development or attendance? ☐ Yes ☐ No

Moderately impacts child development or attendance? ☐ Yes ☐ No

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 (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 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* \_\_\_\_\_

*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_