

2021-2022 ECEAP Prescreen & Application (Combined Form)

School Year Applying for: _____

Return to: _____

Section 1: Child Information

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

- | | |
|---|--|
| <ul style="list-style-type: none"> 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 | <p>Child's first language:
_____</p> <p>Child's second language:
_____</p> |
|---|--|

Is this child Hispanic/Latino? Yes No

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

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

- | | | |
|---|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Chehalis | <input type="checkbox"/> Fijian |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Chinook | <input type="checkbox"/> Guamanian |
| <input type="checkbox"/> Aleut (Unangan) | <input type="checkbox"/> Colville | <input type="checkbox"/> Kosraean |
| <input type="checkbox"/> Alutiiq | <input type="checkbox"/> Cowlitz | <input type="checkbox"/> Mariana Islander |
| <input type="checkbox"/> Athabaskan | <input type="checkbox"/> Duwamish | <input type="checkbox"/> Marshall Islander |
| <input type="checkbox"/> Eskimo (Inupiaq or Yupik) | <input type="checkbox"/> Hoh | <input type="checkbox"/> Melanesian |
| <input type="checkbox"/> Eyak | <input type="checkbox"/> Jamestown | <input type="checkbox"/> Micronesian |
| <input type="checkbox"/> Haida | <input type="checkbox"/> Kalispel | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Tlingit | <input type="checkbox"/> Kikiallus | <input type="checkbox"/> Palauan |
| <input type="checkbox"/> Tsimshian | <input type="checkbox"/> Lower Elwha | <input type="checkbox"/> Papua New Guinean |
| <input type="checkbox"/> Other Alaska Native | <input type="checkbox"/> Lummi | <input type="checkbox"/> Ponapean (Pohnpeian) |
| | <input type="checkbox"/> Makah | <input type="checkbox"/> Samoan |
| | <input type="checkbox"/> Muckleshoot | <input type="checkbox"/> Solomon Islander |
| | <input type="checkbox"/> Nisqually | <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"/> Quinault | <input type="checkbox"/> Vanuatuan/New Hebrides |
| | <input type="checkbox"/> Samish | <input type="checkbox"/> Yapese |
| | <input type="checkbox"/> Sauk-Suiattle | <input type="checkbox"/> Other Pacific Islander |
| | <input type="checkbox"/> Shoalwater | |
| | <input type="checkbox"/> Skokomish | |
| | <input type="checkbox"/> Snohomish | |
| | <input type="checkbox"/> Snoqualmie | |
| | <input type="checkbox"/> Snoqualmoo | |
| | <input type="checkbox"/> Spokane | |
| | <input type="checkbox"/> Squaxin Island | |
| | <input type="checkbox"/> Steilacoom | |
| | <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 | |
-

Section 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.**

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
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.

Section 3: Family Contact Information

Contact 1:	Relationship to Child:			
Parent's Birth Date:	Do you need an interpreter to communicate with English speakers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language(s) do you speak?			
Physical Address	Apt Number	City	State	Zip
Mailing Address	Apt Number	City	State	Zip
Email	Phone	Alternate Phone		
Contact 2:	Relationship to Child:			
Parent's Birth Date:				
Contact 3:	Relationship to Child:			
Parent's Birth Date:				
Contact 4:	Relationship to Child:			
Parent's Birth Date:				

Section 4: Child lives with

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

Two parents/guardians in same household (Names): _____

_____ , _____

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**, ECEAP will count the income from the legal parent/guardian for each household. Do not include their spouses. Enter the legal parents' names here:

Contact 2:	Relationship to Child:			
Parent's Birth Date:	Do you need an interpreter to communicate with English speakers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language(s) do you speak?			
Physical Address	Apt Number	City	State	Zip
Mailing Address	Apt Number	City	State	Zip
Email	Phone	Alternate Phone		

Section 5: Parent Employment, Training, and Other Activities

Answer the following questions for each parent/guardian listed in question #3.

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:
Employed?	<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		
In school or job training?	Yes No	Yes 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.		
Travel between child care and work/school?	Yes No	Yes No
a. If yes, hours per week (maximum 10)		
CPS/FAR/ICW child care hours not counted above?	<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		
Approved WorkFirst hours not counted above?	<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		
Disabled parent 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
If either parent has more than 55 hours total per week, explain:		

Section 6: 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

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

Section 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

Section 9: 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 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? _____

Section 10: 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
Name of Early ECEAP contractor:

ESIT – Early Support or Infants
Name of ESIT Provider:

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

Section 11: 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 | Intellectual disability | Specific learning disability |
| Deaf-blindness | Multiple disabilities | Speech or language impairment |
| Developmental delay | Orthopedic impairment | Traumatic brain injury |
| Emotional disturbance | Other health impairment | Visual impairment |
| Hearing 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 12:

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 13: 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:	Yes	No
• Severely impacts their ability to engage in work, school, or family life?		
• 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?		

Section 14: Parent Education Level – Check all that apply

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		

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:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	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
<input type="checkbox"/> Washington Apple Health for Kids/ Provider One Services Card						
<input type="checkbox"/> Military Coverage <input type="checkbox"/> Private Medical Insurance <input type="checkbox"/> 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
<input type="checkbox"/> Washington Apple Health for Kids/ Provider One Services Card						
<input type="checkbox"/> Military Coverage <input type="checkbox"/> Private Dental Insurance <input type="checkbox"/> Tribal Coverage						
<input type="checkbox"/> 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 _____