

Accepting Applications for (Birth to Five)

Head Start/Early Head Start and Early Childhood Education and Assistance Program (ECEAP)

Dear Families,

The Head Start and Early Childhood Education and Assistance Program (**ECEAP**) of Whitman County wants to invite you to enroll your child in our local preschool program. Classes meet at sites throughout Whitman County with no charge to qualifying families.

The St. James site is a 'Working day' ECEAP program (7:30-5:30) (parents must be working/going to school). The Colfax site, is four days, (M-Th, 8:00 to 3:00) and all other sites are four days a week, 3 to 3 ½ hours a day. Your child will have fun while mastering preschool skills and preparing for kindergarten. Priority will be given to children who will turn three or four years old by August 31, 2023. However, children who turn three years old after this date will be considered.

Early Head Start (EHS) is a federally funded program for families with infants, toddlers and expecting mothers. Early Head Start is a **Home Based/full year program**. Family Consultants provide 90-minute home visits once a week to support parents in their role as their child's first and foremost teacher. Additionally, twice a month, families will have socialization play groups to promote social and learning skills for both children and their parents.

Most families must meet specific income guidelines in order to qualify for these programs. Attached is an application to begin the process of enrolling your child. **You must complete the application form, submit income, age proof, and immunization records if you would like your child considered for Head Start/EHS or ECEAP.**

Any information we are given is kept in strict confidence.

Thank you for your interest in the Head Start / EHS and ECEAP programs. If you have a friend who is interested in these programs or if you need help completing the application, please call at (509) 334-9290, toll free at (877) 909-7005 or fax to (509) 332-5108. We look forward to meeting your family!

Sincerely,

Mona Younes
Enrollment Recruitment Specialist

Please fill out the enclosed application and send us verification of your income and your child's age so we can complete the enrollment process. Income can be verified by any of the following documents:

1. If employed, you may send a copy of your 2022 income tax, W-2, or pay stubs for the past twelve months.
 2. Temporary Assistance for Needy Families (TANF) Benefit History Listing
 3. Foster Child Payment (this may be provided by your caseworker).
 4. Supplemental Nutrition Assistance Program (SNAP) Basic Food Assistance .
 5. Child support order or support enforcement payment printout.
 6. Financial aid award papers. (Form 1098-T Tuition Statement from your college).
 7. If you are not employed and do not receive any of the above support, please state the source of your income and provide proof: _____
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Your child's date of birth may be verified by any of the following documents:

1. A copy of their birth certificate (hospital or live birth certificate).
2. Visa or passport
3. Baptism records
4. Medical coupon
5. Immunization records from medical facility
6. Others

Please send copies of these documents, do not send originals! The information that you provide is confidential and will not be used for any other purpose except to verify the eligibility of your child for the program. We will be in touch with your family to let you know your eligibility status. If you have any questions, please call us at (509) 334-9290 or toll free at (877) 909-7005.

Please be aware that any family member who intentionally attempts to provide or provides false information will result in the termination of the application.



COMMUNITY CHILD CARE CENTER

530 NW Greyhound Way Pullman, WA. 99163 (509) 334-9290

Head Start/EHS/ECEAP/Child Care

ECEAP/Head Start/EHS Application

The Department of Children, Youth and Family keeps the identity of individual children and families confidential to the extent allowed by state and federal law.

1. Child Information

Legal First Name _____ Legal Last Name _____

Child's birth date ____/____/____ Gender: M___ F___

Is this child a member of a tribal nation? Yes No

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? (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 in a cooperative living arrangement with relatives or friends
- 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

For staff use only

Child birth date verified by viewing:

- Adoption Papers
- Birth Certificate
- Certificate of Degree of Indian Blood (CDIB)
- Child Profile
- Court Documents
- Foster Care Authorization Letter
- Government Document with Date of Birth
- IEP
- Immunization Record
- Medical Card or Records
- Medical Record of Birth
- Passport or Visa
- Paternity Affidavit
- Permanent Resident (Green) Card
- School Records
- Other

Language: The child speaks (select one only): 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, please specify** _____

What race (s) do you consider your child? Child's race (check all that apply):

- White Black or African American Alaska Native (please specify) _____
 American Indian (please specify) _____ Asian (please specify) _____
 Native Hawaiian or Pacific Islander (please specify) _____
 Decline to report child's ethnicity Decline to report child's race

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 and State median income (SMI)

First Name	Last Name	Birth date	Relationship to enrolled child	Does this parent financially support this child?	Is this person related to the enrolling child's parent/guardian by blood, marriage, or adoption?
Enrolled Child			Enrolled Child	Yes/No	Yes/No
Parent/guardian				Yes/No	Yes/No
Parent/guardian				Yes/No	Yes/No
				Yes/No	Yes/No
				Yes/No	Yes/No
				Yes/No	Yes/No

**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 enrolled child's parents pay more than half of their expenses.

Family size verified by viewing:	
<input type="checkbox"/> Benefits letter (TANF, SSI, etc.)	<input type="checkbox"/> Foster care grant (for child-only application)
<input type="checkbox"/> Tax records from previous year (1040)	<input type="checkbox"/> Rental/housing document
<input type="checkbox"/> Provider One health insurance	<input type="checkbox"/> Signed application or parent statement
<input type="checkbox"/> School Records	<input type="checkbox"/> Court or Legal Document
<input type="checkbox"/> Other _____	

3. Parent/Guardian Contact Information

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

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

Parent/guardian #1 Name _____	Gender M__ F__	Phone _____
Email (Please write clearly) _____		
Street Address _____	City _____	Zip _____
Mailing address (if different) _____	City _____	Zip _____

Parent/guardian #2 Name _____	Gender M__ F__	Phone _____
Email (Please write clearly) _____		
Street Address _____	City _____	Zip _____
Mailing address (if different) _____	City _____	Zip _____

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, complete these questions to determine which parents' income is counted for program eligibility.*

Does one household have primary legal custody? Yes ____ No ____

If **yes**, which parent has primary custody? _____

Spouse of parent with primary custody, 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 parent with primary custody, if any: _____ (Skip to Section 5)

If **no**, **Program will count the income from the legal parent/guardian** for each household. Do not include their spouses. Enter the legal parents name below.

(Household 1) _____ Household 2) _____

Contact information for Household #2:

Street Address _____ City _____ Zip _____

Mailing address (if different) _____ City _____ Zip _____

Email _____

Phone _____ Alternate Phone _____

Authority to enroll verified by viewing:

- Adoption papers
- Benefits letter showing guardian receives benefit on behalf of the child
- Birth certificate
- Court order, custody order
- Foster care record
- Guardian's income tax return listing child
- Insurance documents stating relationship
- Legal will, describing the relationship
- Letter from social worker, school personnel, lawyer, religious leader, or mental health professional
- Records from DSHS that show guardian as contact for the child
- Records from school, hospital, clinic, other public health, or social service agency
- Written agreement signed and dated by parent and person assuming custodial responsibility
- Passport or Visa
- Other _____

5. Parent Employment Training, and other Activities:

Answer the following questions for each parent/guardian <i>(Do not count the same hours in more than one category)</i>	Parent/Guardian #1 Name <hr/>	Parent/Guardian #2 Name <hr/>
Is this parent/guardian employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, average number of paid hours per week		
b. If yes, enter employer name		
c. If yes, enter employer phone or email.		
In school or job training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, enter class hours per week		
b. If yes, study hours per week (maximum 10 hrs.)		
c. If yes, enter name of school or training organization		
d. If yes, enter goal or major.		
Travel between child care and work/school	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Work First 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 work.	<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.		

6. How did you find out about the ECEAP/Head Start/EHS?

- DCYF Website Community Event Flyer ECEAP Employee Word of Mouth Media
 Caseworker Community Agency (*Name of Agency*): _____
 Other (*Describe*): _____

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:

- 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.

8. Household Situation

- *Does this household receive subsidized housing, such as a housing voucher or cash assistance for housing? Yes No
 *Does this household currently receive a Working Care Connections child care subsidy for this child? Yes No
 *Does this household receive Women, Infant, Children (WIC) Yes No
 *Does this household receive Food Assistance (SNAP) Yes No

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

<p><i>For children in foster or kinship care or adapted after foster or kinship care, fill in this box if applicable and then skip to (Section 10).</i></p> <p>Monthly grant or payment for foster care, kinship care or adoption support: \$ _____</p> <p># of children on grant or payment _____ Case # or Client ID # if any: _____</p> <p>Payment Source (circle): DSHS SSI TRIBE OTHER</p>	<p>Staff verified income by viewing:</p> <p>_____</p> <p>_____</p>
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- Did you receive income during the last calendar year or during the previous 12 months? Yes No
- If no, provide the reason for no income and explain how basic needs are met:
-

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

Select one: Previous calendar year Previous 12 months

Person(s) with income	Document Verified	Weekly amount	# of weeks received	Monthly amount	# of months received	Annual Amount	Verified (v)
	W-2					\$	
	W-2					\$	
	Income Tax (1040) or IRS transcript					\$	
	Pay stubs for 12 months					\$	
	Pay stubs for 12 months					\$	
	Social Security or other Retirement benefits			\$		\$	
	Workers Compensation (L&I)	\$					
	Disability income including SSI			\$		\$	
	Child Support received if required by a child support order			\$		\$	
	Unemployment	\$				\$	
	State or Tribal TANF cash assistance			\$		\$	
	Emergency Assistance Cash Payments			\$		\$	
	Self-employment net income			\$		\$	
	Scholarships/grants/fellowships for living expenses						
	Military Leave & Earnings Statement (LES) Count all pay/allowances except BAH, BAS, FSH, HFP/IDP.					\$	
	Tribal Income (taxable)						
	Insurance Payments that are regular (not 1 time)						
	Other income not classified above			\$		\$	
						\$	Subtotal
Subtract	Court order for Child Support paid to another household			\$		-\$	
						\$	TOTAL

*****Please provide document proof of any income marked above.**

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 Unplanned job Loss Loss of wage earned Health/Injury
 Reduced work hours Job loss -Lack of access or ability to afford child care for newborn
 Loss of benefits unexpected circumstance (explain) _____

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

10. Previous Enrollment

Was this child previously enrolled in Head Start in Pullman Yes No

Was this child previously enrolled in Head Start with a different agency Yes No

Was this child enrolled in Early Head Start? Yes No (Name of Early Head Start Grantee) _____

Any birth-to-three home visiting program and toddler? Yes No

Was this child enrolled in Early Support for Infants and Toddlers (ESIT or IFSP)? Yes No

Migrant/Seasonal Head Start anywhere in Washington Yes No

Part C IDEA Early Intervention program in another state Yes No (Name of State and Provider) _____

Early ECEAP Yes No (Name of Early ECEAP Contractor) _____

Was this child enrolled in Early Childhood Intervention Prevention Services (ECLIPSE) Yes No

11. IEP or Suspected Delay

- This child has an Individualized Education Program (IEP)?
 - Child was determined eligible for special education services through evaluation by a school district or tribal school, but parent/guardian declined services.
 - 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 question 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? _____

This child will receive IEP services:

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

12. Has this child been expelled from any early learning program or child care due to behavior? Yes No
(Head Start/EHS/ECEAP serves children with behavior issues. Checking yes will not exclude your child.)

13. Additional Questions

*We use this information below to prioritize the children who need the program the most.
All responses are kept confidential.*

- Does this child have a household family member who has a chronic physical or mental health condition?
- 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) or moves to engage in agriculture or fishing work? Yes No
- Does this child have a parent who is currently on active duty in the U.S. military? Yes No
- Does this child have a parent who is currently on active duty in the National Guard/Military Reserve? Yes No
- Does this child have a military parent deployed currently, or within the past 12 months, or for over 19 months within the child's life time? Yes No
- Does this child have a family who attended an Indian boarding school? Yes No
- Has this child experienced a parent 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 homeless 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 child 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 parent after foster or kinship care in the past 12 months? Yes No
- The program received a professional referral for this child
If yes, name of referring agency: _____ Yes No
- Is the mother pregnant or has there been a newborn in the past 12 months? Yes No

14. Parent Information: Check (v) each parent's highest level of education and part time or full-time school/employment.

	Employment	Employed full-time	Employed part-time	Unemployed	Education	In educational program full-time	In educational program part-time	6 th grade or less	7th to 12th grade, no diploma or GED	High school diploma or GED	Some college	Professional Certificate (Vocational Schools)	Associate degree	Bachelors degree	Masters degree or doctorate
Parent/Guardian #1 name _____															
Parent/Guardian #2 name _____															

15. 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 week), or weighed less than 5.5 pounds when they were born?

Yes No Unknown

Does this child have medical insurance or coverage?

Washington Apple Health for Kids / Provider One Services Card

Military Coverage

Private Medical Insurance Tribal Coverage

No medical coverage

Does this child have a regular doctor or medical clinic?

Yes No Unknown

Name of clinic or provider: _____ Phone # _____

Name of Doctor: _____

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 Program ____/____/____ Date Unknown

Does this child have dental insurance or coverage?

Washington Apple Health for Kids / Provider One Services Card

Military Coverage

Private Dental Insurance ABCD Tribal Coverage

No dental coverage

Does this child have a regular dentist or dental clinic?

Yes No Unknown

Name of clinic or provider: _____ Phone # _____

Name of Dentist: _____

Did this child have a dental screening within the last 6 months? Yes No Unknown

Date of last dental screening before applying for Program ____/____/____ Date Unknown

Immunization Status:

- Complete** - child presented a signed Certificate of Immunization Status (CIS) form showing sufficient immunization dates.
- Exempt** - child presented a signed Certificate of Exemption (COE) form certifying that the child is exempt for one or more vaccines for medical, persona/philosophical or religious reasons.
- Conditional** - child presented a signed CIS form that does not meet the requirements, but has proof of initiation or continuation of a schedule of immunizations AND is within the recommended interval for the next dose.
- Out of Compliance** - child does not have a signed, completed CIS form.
- Out of Compliance** - child is not exempt and has not received immunization required for their age.
- Child's signed Certificate of Immunization Status has not been evaluated

Signature of Parent/Guardian

I promise that the information on this application is accurate and truthful to the best of my knowledge. I have reported all my income and family size as required by the program. I am aware that, if I knowingly provide false information, my child could be disqualified from the program. Additionally, I may have to repay the amount spent on my child. I give permission for the program to share my information with other state agencies, research firm and internal databases for the purposes of data reporting and providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of participant information. No information related to immigration status is entered in any data base or shared with any state or federal agencies.

Print name _____ *Signature* _____ *Date* _____

Signature of 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 the program. I understand that I am required to notify DCYF or Head Start if I suspect any fraudulent use of programs funds. Any intentional attempt by staff to enroll families who are not eligible into the program will result in termination of employment.

- 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 Head Start/ EHS/ ECEAP.

Staff: Print name _____ *Signature* _____ *Date* _____