

2023-2024 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 State Median Income (SMI).**

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 SMI 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 10*

- 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			\$		\$
	State or Tribal TANF Grants			\$		\$
	Unemployment	\$				\$
	Workers Compensation (L&I)	\$				\$
	Tribal income (taxable)					\$
	Emergency Assistance Cash Payments			\$		\$
	Insurance Payments that are regular (not 1 time)			\$		\$
	Retirement or pension plans					
	Training Stipend					
	Scholarship, Grants, or Fellowships for living expenses					
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)
Job loss - lack of access or ability to afford child care

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 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 Section 6.*

- | | | |
|--|--|--|
| <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

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: <i>(if yes select one)</i>				
<ul style="list-style-type: none"> Severely impacts their ability to engage in work, school, or family life? 		Yes		No
<ul style="list-style-type: none"> 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?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does this child have a parent who: <i>(if yes select one)</i>				
<ul style="list-style-type: none"> Is a migrant or seasonal agricultural worker? <i>(51% or more of family income from agricultural work)</i> 		Yes		No
<ul style="list-style-type: none"> Moves with child to engage in traditional cultural practices or employment <i>(seasonal or temporary in agricultural or fishing work)?</i> 		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?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Has this child experienced a parent who is incarcerated in jail, prison, or a detention center?		Yes		No
Has this child experienced the loss of a parent, or primary caregiver, 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 Name _____	Parent/Guardian 2 Name _____
6 th grade or less	<input type="checkbox"/>	<input type="checkbox"/>
7 th to 12 th grade, no diploma or GED	<input type="checkbox"/>	<input type="checkbox"/>
High school diploma or GED	<input type="checkbox"/>	<input type="checkbox"/>
Some college	<input type="checkbox"/>	<input type="checkbox"/>
Professional certificate (includes vocational schools)	<input type="checkbox"/>	<input type="checkbox"/>
Associate degree	<input type="checkbox"/>	<input type="checkbox"/>
Bachelor's degree	<input type="checkbox"/>	<input type="checkbox"/>
Master's degree or doctorate	<input type="checkbox"/>	<input type="checkbox"/>

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?

❖ 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 _____