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

Early Childhood Education & Assistance Program

Washington State Department of Early Learning

ECEAP Application

Child's Name _____

Parent/Guardian Name_____

For assistance completing this form, call: (509) 544-5704 or email: tosborne@esd123.org

Mail or drop off applications at the ESD123 located at 3924 W Court St. Pasco WA 99301

Please circle your location below.

Pasco | Burbank | Connell | Mesa | Finley | Othello

1. Family Info: Other Household Members *(Optional)*

First Name	Last Name	Gender	Relationship to Child	Age, if under 19	Birthdate, if under 5

2. Family Info: Second Household

If this child has one household, skip to section 3.

Parent/Guardian name(s) _____

Street Address _____ City _____ Zip_____

Mailing address (if different) _____ City _____ Zip_____

Phone _____ Alternate Phone _____ Email _____

3. 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 Connections child care subsidy for this child? ☐ Yes ☐ No

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

If this child is homeless and <u>not</u> living with a parent or guardian, skip to section 5.
If this child is in foster care or living with a guardian who receives a TANF grant for the child, fill in this information, then skip to section 5. Monthly foster care or SSI grant for child $_____ Foster care or SSI case number _____ Monthly grant amount $_____ # of children on grant ____ TANF Client ID number _____

- Did this family receive income during the last calendar year or during the previous 12 months? ☐ Yes ☐ No
- Enter all family income for one year in the chart below.
  - Select either: ☐ Previous calendar year ☐ Previous 12 months

Name of person(s) receiving 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					$
	Child Support received			$		$
	Disability income, including SSI, for any family member			$		
	Military Leave & Earnings Statement (LES). Count all pay and allowances except BAH, BAS 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)	$				
	Other income not classified above			$		$
						$
Subtract	Child support paid to another household, if required by a legally-binding child support order			$		-$
					TOTAL	$

Do you still receive the income above? ☐ Yes ☐ No

If yes, skip to section 5.

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

☐ Divorce or separation ☐ Loss of job ☐ Job Changed ☐ Loss of wage earner
☐ Loss of benefits ☐ Other (explain) _____

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

5. Previous Enrollment

Was this child previously enrolled in Head Start (for preschoolers)? ☐ Yes ☐ No If yes, where? _____

Was this child enrolled in Early Head Start or a birth-to-three home visiting program? ☐ Yes ☐ No

Did this child have a Family Resource Coordinator (ESIT program)? ☐ Yes ☐ No

Does this child have an Individualized Education Program (IEP)? ☐ Yes ☐ No

If this child has an IEP check all categories of the IEP. If not, skip to next question.

☐ 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		

What school district issued this child's IEP? _____

Is a school district special education preschool available for this child? ☐ Yes ☐ No

Has this child been asked to leave a child care or preschool because of behavior issues? ☐ Yes ☐ No

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

6. Additional Questions

We use this information to choose the children who most need ECEAP. All responses will be kept confidential.

Is this child an English language learner (speaks another language and is learning English)? ☐ Yes ☐ No

Has this child been homeless within the last 12 months? ☐ Yes ☐ No

Does this child have a parent who is developmentally or physically disabled? ☐ 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 parent who is currently or was recently deployed to a combat zone? ☐ Yes ☐ No

Does this child have a parent who is incarcerated in jail, prison or a detention center? ☐ Yes ☐ No

Does this child have a parent experiencing mental health issues (including maternal depression)? ☐ 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 worker? ☐ Yes ☐ No

Has your family received services from Child Protective Services (CPS) in the past? ☐ Yes ☐ No

Has your family ever experienced domestic violence? ☐ Yes ☐ No

Does your family struggle with substance abuse issues? ☐ Yes ☐ No

Do you have a support system outside of your family (people you can talk to and people who help you)? ☐ Yes ☐ No

7. Parent Education Level: Check all that apply (√)

Highest level of education	Parent/ Guardian 1 Name_____	Parent/ Guardian 2 Name_____
6th grade or less		
7th to 12th grade, no diploma or GED		
High school diploma or GED		
Some college		
Associate degree		
Bachelors degree		
Masters degree or doctorate		

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

Does this child have a chronic health condition such as diabetes, asthma, seizures, etc? ☐ Yes ☐ No

If yes, please describe _____

Does this child have any known allergies? ☐ Yes ☐ No

If yes, please describe _____

Did this child weigh less than 5.5 pounds when they were born? ☐ Yes ☐ No ☐ Unknown

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

☐ DSHS Provider One Services Card ☐ Washington Basic Health ☐ Military Medical Coverage

☐ Private Medical Insurance ☐ Tribal Coverage

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

Clinic Name_____

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

☐ DSHS Provider One Services Card ☐ Washington Basic Health ☐ Military Dental Coverage

☐ Private Dental Insurance ☐ ABCD (not available in all counties)

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

Clinic Name_____

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 certify that the information on this form is true and correct. I understand that this information may be reported to other state agencies or research firms. The Department of Early Learning keeps the identity of individual children and families confidential to the extent allowed by state and federal law.

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.

Signature _____ *Date* _____