Early Childhood Education & Assistance Program
Washington State Department of Early Learning

2019-20 ECEAP Application

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

Child's Name _____

Parent/Guardian Name_____

For assistance completing this form, call: (509) 559-4828 or email: jsmylie@cheneysd.org

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.

				Skip these two questions if ECEAP child is in foster care or living with a guardian who receives a payment for care.	
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

**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 expenses.*

For staff use only:
Family size for FPL chart _____
For children in foster care or kinship care with a payment, count family size as 1.
For all others, count people with Yes for both questions above.

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

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

For children in foster or kinship care:

*If this child is in foster care or living with a guardian who receives a payment for the child, fill in this box and **skip to section 4.***

Monthly grant or payment amount $_____ # of children covered by this grant amount_____

Case # or Client ID #_____ Payment source: DSHS☐ SSI☐ Tribe☐ Other

Did you receive income during the last calendar year or during the previous 12 months? ☐ Yes ☐ No

If **no**, describe reason family does not have income:_____

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			$		$
	Child-only TANF or foster care grant for non-ECEAP child			$		$
	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			$		-$
					TOTAL	$

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:

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

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

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 Washington
☐ Early Head Start
☐ Any birth-to-three home visiting program
☐ ESIT - Early Support for Infants and Toddler

5. IEP or Suspected Delay

☐ This child has an Individualized Education Program (IEP).
☐ This child has a suspected developmental delay or disability.

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? _____

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

6. 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.

7. Additional Questions

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

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 this child's family received services from Child Protective Services (CPS) or similar Indian Child Welfare (ICW) services in the past? ☐ Yes ☐ No

Has this child's family ever experienced domestic violence? ☐ Yes ☐ No

Does this child's family struggle with substance abuse issues? ☐ Yes ☐ No

Does this family have a support system outside of the household? ☐ Yes ☐ No

ECEAP received a professional referral for this family. ☐ Yes ☐ No

If yes, which agency made the referral? _____

8. 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		
Professional certificate (includes vocational schools)		
Associate degree		
Bachelor's degree		
Master's degree or doctorate		

9. 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 _____

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

☐ Washington Apple Health for Kids/ Provider One Services Card

☐ Military Dental Coverage ☐ Private Dental 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 certify that the information on this form is true and correct. I understand that, if I knowingly provide false information, my child could be disqualified from ECEAP and I may have to reimburse the amount spent on my child's ECEAP services ($780 or more per month).

I understand that information in this application may be combined with information about other ECEAP children and used for research studies, such as determining if participating in ECEAP helps children later in life. The identities of children and families would be removed before analyzing information for research.

I understand that information in this application may be reported to other state agencies. For example, individual child enrollment dates could be used to determine if state dollars spent on ECEAP may be used as "federal match" to allow Washington to receive more federal funds to serve families.

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 Child, Youth, and Families (formerly Department of Early Learning) 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* _____

SUBMIT