

How to Apply for Puget Sound ESD Early Learning Programs

Welcome!

Please complete one application packet per child and attach the requested documents.

Your information is confidential. We do not require, check on, or report on immigration status.

Eligibility to our programs is determined by child's age and family income, not by the date you applied.

Our programs fill up fast, so please apply as soon as you can!



Contact us if you need help to complete the application, or if you do not have all of the requested documents.

Please follow the steps below:



Fill out the application form using a black or blue pen.



Attach a copy of your child's proof of birth date.



Attach a copy of your proof of legal guardianship.



Attach a copy of your proof of family income.



Attach a copy of proof of family size.

Use one of these:

- Birth Certificate
- Passport/Visa
- Adoption Papers
- Foster Care Authorization Letter
- Current Immunization Record

Use one of these:

- Birth Certificate
- Passport/Visa
- Adoption Papers
- Foster Care Record
- Written agreement signed and dated by parent and person assuming custodial responsibility

Use all that apply:

- Last year's Income Tax Return
- Last year's W-2 Form
- Pay stubs from the last 12 months
- SSI/TANF benefits letters from the last 12 months
- Foster care grant
- Child support
- Employer letter stating your total gross income from the last 12 months

Use one of these:

- Last year's Income Tax Return
- Housing Lease



Call our office if you receive other types of income, not listed above.



Return your completed application and documents to:

Address:

Phone Number:

It would be helpful to also include a copy of your child's current immunization record.

If your child has a current IFSP/IEP, please attach a copy to your application, as well.

Please make sure that your proof of income is included. We cannot process your application without this information.

Remember to return your completed application as soon as possible! Thank you for choosing our Early Learning Programs!

Early Learning Application 2018-2019

STAFF ONLY	Date received:	Site Name/ID:	❖ ELMS Prescreen Questions	<input type="checkbox"/> + <input type="checkbox"/> TOTAL	Child's Age
	Date staff reviewed application with family:	HS/EHS ONLY - Date sent to PSESD:			
	Is this child a newborn taking the mother's slot? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, mother's name: _____	Is this child currently enrolled in a community slot at this center? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this child's sibling currently enrolled in a community slot at this center? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="radio"/>	

The information on your application is confidential and used only to determine your child's eligibility for our Early Learning Programs. We do not require, check, or report on immigration status.

CHILD INFORMATION	Child Information	
	❖ First Name: _____	Middle Initial: _____ Last Name: _____
	❖ Date of Birth: ____/____/____ Month/Day/Year Please include proof of birth date with this application	❖ Gender: _____
	Collecting the information below helps us to determine the most culturally appropriate services and supports unique to your child and family.	
	❖ What is your child's home language? _____	
	❖ Is your child Hispanic/Latino? <input type="checkbox"/> Yes - Please describe or write the country of origin: _____ <input type="checkbox"/> No	
	❖ What is your child's race? Check all that apply:	
	<input type="checkbox"/> African/African American/Black ➤ Please describe or write the tribe/country of origin: _____ <input type="checkbox"/> Asian ➤ Please describe or write the tribe/country of origin: _____ <input type="checkbox"/> Alaska Native/Native American/American Indian ➤ Please describe or write the tribe/country of origin: _____ <input type="checkbox"/> Native Hawaiian or Pacific Islander ➤ Please describe or write the tribe/country of origin: _____ <input type="checkbox"/> White ➤ Please describe or write the tribe/country of origin: _____	
	If not listed above, please describe your child's heritage: _____	
	Has your child previously attended any of these programs?	
<input type="checkbox"/> Birth-to-3 Home Visiting Program <input type="checkbox"/> Head Start <input type="checkbox"/> Early Support for Infants and Toddlers (ESIT) <input type="checkbox"/> Migrant/Seasonal Head Start anywhere in Washington <input type="checkbox"/> Early Head Start <input type="checkbox"/> ECEAP <input type="checkbox"/> Parents as Teachers <input type="checkbox"/> No		
When did your child last attend? _____ Name and location of program: _____		
❖ Is your child in official foster/kinship care? (A caregiver authorization from a state or tribe that says child is a foster/kinship placement)		
<input type="checkbox"/> Yes <input type="checkbox"/> No ➤ Has your child been in foster/kinship care in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your child ever been asked to leave a childcare center or preschool because of behavior issues? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your child experienced abuse or neglect? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your child been diagnosed by a Health Care Provider with one or more serious/chronic health conditions, such as asthma, diabetes, seizures, heart condition, or life-threatening allergies?		
<input type="checkbox"/> Yes - Please describe: _____ <input type="checkbox"/> No		

CHILD INFORMATION	Child Information																	
	Do you suspect that your child has a developmental delay or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
	Does your child have a current Individual Family Service Plan (IFSP) or Individual Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
	If yes, please answer the following questions and include a copy of the IFSP or IEP with this application																	
	➤ Please check all categories of the IEP/IFSP: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Autism</td> <td><input type="checkbox"/> Intellectual disability</td> <td><input type="checkbox"/> Specific learning disability</td> </tr> <tr> <td><input type="checkbox"/> Deaf-blindness</td> <td><input type="checkbox"/> Multiple disabilities</td> <td><input type="checkbox"/> Speech/language impairment</td> </tr> <tr> <td><input type="checkbox"/> Developmental delay</td> <td><input type="checkbox"/> Orthopedic impairment</td> <td><input type="checkbox"/> Traumatic brain injury</td> </tr> <tr> <td><input type="checkbox"/> Emotional disturbance</td> <td><input type="checkbox"/> Other health impairment</td> <td><input type="checkbox"/> Visual impairment</td> </tr> <tr> <td><input type="checkbox"/> Hearing impairment</td> <td></td> <td></td> </tr> </table>			<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/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		
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<input type="checkbox"/> Emotional disturbance	<input type="checkbox"/> Other health impairment	<input type="checkbox"/> Visual impairment																
<input type="checkbox"/> Hearing impairment																		
➤ Is Special Ed Preschool or Birth-to-3 Program available/easily accessible to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know																		
Do you have concerns about your child's health and development? Check all that apply:																		
<table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Low birth weight (less than 5.8 lbs.)</td> <td><input type="checkbox"/> Mental health – Please describe: _____</td> <td><input type="checkbox"/> Behavior – Please describe: _____</td> </tr> <tr> <td><input type="checkbox"/> Hearing</td> <td><input type="checkbox"/> Food intolerance/special diet – Please describe: _____</td> <td><input type="checkbox"/> Speech/language</td> </tr> <tr> <td><input type="checkbox"/> Vision</td> <td></td> <td><input type="checkbox"/> Fine motor/gross motor</td> </tr> <tr> <td><input type="checkbox"/> Tooth pain/decay/bleeding gums</td> <td></td> <td><input type="checkbox"/> Other – Please specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Drug/alcohol affected</td> <td></td> <td></td> </tr> </table>			<input type="checkbox"/> Low birth weight (less than 5.8 lbs.)	<input type="checkbox"/> Mental health – Please describe: _____	<input type="checkbox"/> Behavior – Please describe: _____	<input type="checkbox"/> Hearing	<input type="checkbox"/> Food intolerance/special diet – Please describe: _____	<input type="checkbox"/> Speech/language	<input type="checkbox"/> Vision		<input type="checkbox"/> Fine motor/gross motor	<input type="checkbox"/> Tooth pain/decay/bleeding gums		<input type="checkbox"/> Other – Please specify: _____	<input type="checkbox"/> Drug/alcohol affected			
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<input type="checkbox"/> Tooth pain/decay/bleeding gums		<input type="checkbox"/> Other – Please specify: _____																
<input type="checkbox"/> Drug/alcohol affected																		
Does this child have medical insurance?																		
<input type="checkbox"/> Yes – What type? <table style="width:100%; border:none;"> <tr> <td>➤ <input type="checkbox"/> Washington Apple Health/ProviderOne</td> <td><input type="checkbox"/> Private Insurance</td> <td><input type="checkbox"/> Tribal or Military Medical Coverage</td> </tr> </table> <input type="checkbox"/> No			➤ <input type="checkbox"/> Washington Apple Health/ProviderOne	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Tribal or Military Medical Coverage													
➤ <input type="checkbox"/> Washington Apple Health/ProviderOne	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Tribal or Military Medical Coverage																
Does this child have a regular doctor or medical clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
Did this child have a well-child exam within the last 12 months? <input type="checkbox"/> Yes – Date of last exam: ___/___/___ <input type="checkbox"/> Date Unknown <input type="checkbox"/> No																		
Does this child have dental insurance?																		
<input type="checkbox"/> Yes – What type? <table style="width:100%; border:none;"> <tr> <td>➤ <input type="checkbox"/> Washington Apple Health/ProviderOne</td> <td><input type="checkbox"/> Private Insurance</td> <td><input type="checkbox"/> Tribal or Military Dental Coverage</td> </tr> </table> <input type="checkbox"/> No			➤ <input type="checkbox"/> Washington Apple Health/ProviderOne	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Tribal or Military Dental Coverage													
➤ <input type="checkbox"/> Washington Apple Health/ProviderOne	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Tribal or Military Dental Coverage																
Does this child have a regular dentist or dental clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
Did this child have a dental screening in the last 6 months? <input type="checkbox"/> Yes – Date of last screening: ___/___/___ <input type="checkbox"/> Date Unknown <input type="checkbox"/> No																		

FAMILY INFORMATION	Family Information	Parent/Guardian 1	Parent/Guardian 2
	❖ Name:		
	❖ Relationship to Child:	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other
	❖ Date of Birth:	___/___/___ Month/Day/Year	___/___/___ Month/Day/Year
	How old were you when this child was born?	_____	_____
	❖ Address:		
	❖ Phone:	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	❖ Alternate Phone:	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	❖ Email Address:		

Family Information	Parent/Guardian 1	Parent/Guardian 2	
<ul style="list-style-type: none"> ❖ Do you need an interpreter? ❖ What language(s) do you speak? 	<input type="checkbox"/> Yes <input type="checkbox"/> No 	<input type="checkbox"/> Yes <input type="checkbox"/> No 	<input type="checkbox"/>
Did you get a high school diploma or GED? What is the highest degree you completed?	<input type="checkbox"/> GED <input type="checkbox"/> High school diploma <input type="checkbox"/> None – What is the highest grade you completed? _____ <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College degree/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor’s degree <input type="checkbox"/> Master’s degree <input type="checkbox"/> None	<input type="checkbox"/> GED <input type="checkbox"/> High school diploma <input type="checkbox"/> None – What is the highest grade you completed? _____ <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College degree/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor’s degree <input type="checkbox"/> Master’s degree <input type="checkbox"/> None	<input type="checkbox"/>
<ul style="list-style-type: none"> ❖ Are you currently employed? ❖ Are you currently in job training or school? ❖ Are you in an approved WorkFirst activity? 	<input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal <input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe the activity and number of approved hours per week: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal <input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe the activity and number of approved hours per week: _____ <input type="checkbox"/> No	
Are you on active U.S. military duty? Are you a member of a National Guard or Military Reserve unit? Are you a U.S. military veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please check areas of concern that you have for yourself/family in your household that we may be able to assist you with:			
<input type="checkbox"/> Previously homeless (in the last 12 months) <input type="checkbox"/> Child’s parent/guardian is disabled <input type="checkbox"/> Child’s parent/guardian is currently deployed to a combat zone, or was within the last year <input type="checkbox"/> Child’s parent/guardian is incarcerated			<input type="checkbox"/>
<input type="checkbox"/> Household mental illness/counseling, including maternal depression. <input type="checkbox"/> Child’s parent/guardian is a migrant worker <input type="checkbox"/> Household domestic violence (past or current) <input type="checkbox"/> Household drug/alcohol issues or substance abuse <input type="checkbox"/> Family has little or no support from other family or friends			
<input type="checkbox"/> Other household members have no medical/dental insurance <input type="checkbox"/> Other household members have no medical/dental home <input type="checkbox"/> Child’s parent/guardian has health concerns <input type="checkbox"/> Child’s parent/guardian has learning difficulties			<input type="checkbox"/>
<input type="checkbox"/> Getting or keeping a job <input type="checkbox"/> Concerns with housing <input type="checkbox"/> Legal concerns <input type="checkbox"/> Recent immigrant/refugee (past 5 years)			<input type="checkbox"/>

FAMILY INFORMATION

Family Information																		
❖ Child lives with: <ul style="list-style-type: none"> ➤ <input type="checkbox"/> One parent/guardian ➤ <input type="checkbox"/> Two parents/guardians in same household ➤ <input type="checkbox"/> Two parents/guardians in two households – Does one household have primary legal custody? <ul style="list-style-type: none"> ➤ <input type="checkbox"/> Yes – Which parent has primary custody? _____ ➤ <input type="checkbox"/> No – Does one parent receive child support payments from the other household? <ul style="list-style-type: none"> ➤ <input type="checkbox"/> Yes – Which parent receives the child support payments? _____ ➤ <input type="checkbox"/> No 																		
❖ Please list other people living in your home. Do not include yourself or your child. If you need more space, write on a separate piece of paper and include with your application.																		
Name (First and Last)	Birthdate (Month/Day/Year)	Relationship to Child	Do you financially support this person?	Is this person related to you by blood, marriage, or adoption?														
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No														
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No														
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No														
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No														
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No														
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No														
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No														
❖ Does this child live with a guardian who is not their parent or foster parent? <ul style="list-style-type: none"> ➤ <input type="checkbox"/> Yes <ul style="list-style-type: none"> ➤ Does this person receive a state, tribal, or SSI payment on behalf of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No ➤ <input type="checkbox"/> No 																		
Do you, your child, or another member of your family receive these types of income? Check all that apply: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> TANF</td> <td style="width: 33%;"><input type="checkbox"/> Supplemental Security Income (SSI) for disability</td> <td style="width: 33%;"><input type="checkbox"/> Foster Child Income</td> </tr> <tr> <td> ➤ Is it for child only? <input type="checkbox"/> Yes <input type="checkbox"/> No ➤ Do you have a Working Connections Child Care Subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No </td> <td> ➤ Person's relationship to child: _____ </td> <td></td> </tr> </table>					<input type="checkbox"/> TANF	<input type="checkbox"/> Supplemental Security Income (SSI) for disability	<input type="checkbox"/> Foster Child Income	➤ Is it for child only? <input type="checkbox"/> Yes <input type="checkbox"/> No ➤ Do you have a Working Connections Child Care Subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No	➤ Person's relationship to child: _____									
<input type="checkbox"/> TANF	<input type="checkbox"/> Supplemental Security Income (SSI) for disability	<input type="checkbox"/> Foster Child Income																
➤ Is it for child only? <input type="checkbox"/> Yes <input type="checkbox"/> No ➤ Do you have a Working Connections Child Care Subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No	➤ Person's relationship to child: _____																	
❖ Total estimated household income for the last calendar year or the last 12 months: _____ Please include proof of income and family size with this application.																		
❖ Does your family currently receive services through Child Protective Services (CPS), Family Assessment Response (FAR), or Indian Child Welfare (ICW)? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
❖ Is your family currently approved for child care through CPS or FAR? <input type="checkbox"/> Yes – Number of approved hours per week: _____ <input type="checkbox"/> No																		
❖ Has your family received services from CPS or ICW in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
❖ What is your family's current housing situation? <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other – If this is checked, please complete the attached <i>Housing Questionnaire</i>																		
Does this household receive subsidized housing, such as a housing voucher or cash assistance for housing? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
❖ How did you learn about our program? Check all that apply: <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;"><input type="checkbox"/> Website</td> <td style="width: 15%;"><input type="checkbox"/> Community event</td> <td style="width: 15%;"><input type="checkbox"/> Flyer</td> <td style="width: 15%;"><input type="checkbox"/> Media</td> <td style="width: 15%;"><input type="checkbox"/> Word of mouth</td> <td style="width: 15%;"><input type="checkbox"/> Site staff</td> <td style="width: 15%;"><input type="checkbox"/> Past parent</td> </tr> <tr> <td colspan="5"><input type="checkbox"/> Community agency/Case worker – Please specify: _____</td> <td colspan="2"><input type="checkbox"/> Other – Please specify: _____</td> </tr> </table>					<input type="checkbox"/> Website	<input type="checkbox"/> Community event	<input type="checkbox"/> Flyer	<input type="checkbox"/> Media	<input type="checkbox"/> Word of mouth	<input type="checkbox"/> Site staff	<input type="checkbox"/> Past parent	<input type="checkbox"/> Community agency/Case worker – Please specify: _____					<input type="checkbox"/> Other – Please specify: _____	
<input type="checkbox"/> Website	<input type="checkbox"/> Community event	<input type="checkbox"/> Flyer	<input type="checkbox"/> Media	<input type="checkbox"/> Word of mouth	<input type="checkbox"/> Site staff	<input type="checkbox"/> Past parent												
<input type="checkbox"/> Community agency/Case worker – Please specify: _____					<input type="checkbox"/> Other – Please specify: _____													

I have answered the questions to the best of my knowledge and have provided the requested documentation that I have available.

Parent/Guardian Signature: _____ Date: _____
 (ECEAP Staff: Enter this date in ELMS)



STAFF ONLY: Returning Child Information

Complete if the child is returning for the next program year. Do not reverify income.

Program Year:		Updated Total:
HS/EHS Only – Date Sent to PSESD:		Site/ID Name:
CHILD INFORMATION		
Child's Name:		Child's Date of Birth:
Has the child been diagnosed by a Health Care Provider with one or more serious/chronic health conditions, such as asthma, diabetes, seizures, heart condition, or life-threatening allergies? <input type="checkbox"/> Yes – Please describe: _____ <input type="checkbox"/> No		
Does the family suspect that the child has a developmental delay or disability? <input type="checkbox"/> Yes – Please describe: _____ <input type="checkbox"/> No		
Does the child have a current Individual Family Service Plan (IFSP) or Individual Education Plan (IEP)? <input type="checkbox"/> Yes – Please describe: _____ <input type="checkbox"/> No		
Does the family have concerns about the child's health and development? <input type="checkbox"/> Yes – Please describe: _____ <input type="checkbox"/> No		
Does this child have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does this child have a regular doctor or medical clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this child have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does this child have a regular dentist or dental clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the family have new/additional areas of concern? <input type="checkbox"/> Yes – Please describe: _____ <input type="checkbox"/> No		
FAMILY INFORMATION	Parent/Guardian 1	Parent Guardian 2
Name:		
Relationship to Child:	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other
Address (if changed):		
Phone (if changed):	_____-_____-_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	_____-_____-_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Alternate Phone (if changed):	_____-_____-_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	_____-_____-_____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Email Address (if changed):		
Did the parent/guardian receive a high school diploma or GED?	<input type="checkbox"/> GED <input type="checkbox"/> High school diploma <input type="checkbox"/> None – What is the highest grade completed? _____	<input type="checkbox"/> GED <input type="checkbox"/> High school diploma <input type="checkbox"/> None – What is the highest grade completed? _____
What is the highest degree the parent/guardian completed?	<input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College degree/training certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> None	<input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College degree/training certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> None
Is the parent/guardian currently employed?	<input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal	<input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal
Is the parent/guardian currently in job training or school?	<input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes – How many hours per week? _____ <input type="checkbox"/> No
Is the parent/guardian on active U.S. military duty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the parent/guardian a member of a National Guard or Military Reserve unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the parent/guardian a U.S. military veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the family's current housing situation? (The family must complete the <i>Housing Questionnaire</i> annually, if they continue to meet the definition of homeless) <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other – Please describe: _____		
Staff Name:		Title:
Staff Signature:		Date:

Housing Questionnaire

Site Name and Address

If you own/rent your home, you do not need to complete this form.

The answers to the following questions can help determine the services this student may be eligible to receive. The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. (Please see the next page for more information)

If you do not own/rent your home, please share your current living situation. Check all that apply below:

- Checkboxes for living situations: In a motel, In a shelter, In someone else's house or apartment with another family, In a residence with inadequate facilities, Moving from place to place/couch surfing, A car, park, campsite, or similar location, Transitional Housing, Other - Please describe.

STAFF: Review the ERSEA Procedure for follow up questions.

Name of child: First Middle Last

Birthdate: Month/Day/Year Gender:

- Child is unaccompanied (not living with a parent or legal guardian)
Child is living with a parent or legal guardian

Address of current residence:

Phone Number: Name of contact:

I declare under penalty of perjury under the laws of the State of Washington that the information provided here is true and correct.

Name of parent/guardian:

Signature of parent/guardian:

Date:

SEC. 725. DEFINITIONS

For purposes of this subtitle:

- (1) The terms “enroll” and “enrollment” include attending classes and participating fully in school activities.
- (2) The term homeless children and youths' —
 - (A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and
 - (B) includes —
 - (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals;
 - (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));
 - (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
 - (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).
- (3) The term unaccompanied youth' includes a youth not in the physical custody of a parent or guardian.

Additional Resources

Parent information and resources can be found at the following:

http://center.serve.org/nche/ibt/parent_res.php

<http://www.schoolhouseconnection.org/>

STAFF ONLY

Check the services that are needed or desired by the family and provide resources as soon as possible:

- | | |
|---|--|
| <input type="checkbox"/> Child care resources | <input type="checkbox"/> School transportation (if site provides) |
| <input type="checkbox"/> Clothing resources | <input type="checkbox"/> Hygiene products/toiletries |
| <input type="checkbox"/> School supplies | <input type="checkbox"/> Food resources |
| <input type="checkbox"/> Medical/dental referral | <input type="checkbox"/> Vision referral |
| <input type="checkbox"/> College/vocational/technical resources | <input type="checkbox"/> Medicaid/DSHS services – Food stamps/TANF |
| <input type="checkbox"/> Housing/shelter referral | <input type="checkbox"/> Birth certificate |
| <input type="checkbox"/> Immunization/medical records | <input type="checkbox"/> Other: |

Staff Signature: _____ **Date:** _____