

Section A: Child's Information

Child's Information	Child's First Name: _____ Middle Initial: ____ Last Name: BOX 1: Preschool; 700, 600, 500, 400, <input type="checkbox"/>
	Date of Birth: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Telephone: _____ OR EHS: 100, 50 <input type="checkbox"/>
	Address: _____ CIRCLE: EHS Child Age & BOX 2: 1, 2, 3, 4, or 5 EHS (STAFF ONLY) Age <input type="text"/> <input type="checkbox"/>
	Apartment Name/Number: _____ City: _____ Zip: _____ <input type="checkbox"/>
	What's your child's home language? _____ BOX 3: DLL; 3 <input type="checkbox"/>
	How do you identify your child's race(s)/ethnicity(s)? _____ BOX 4: Opportunity Gap; 15 <input type="checkbox"/>
	During last year, did your child attend? <input type="checkbox"/> Early Head Start <input type="checkbox"/> Head Start and/or ECEAP <input type="checkbox"/>
If yes, name of program: _____ BOX 5: 800/ Preschool; 800 or EHS; 125 <input type="checkbox"/>	

Section B: Eligibility Information

Family Information	Does your family currently receive TANF cash assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes Child-only TANF? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Is your family currently receiving Childcare Subsidy? <input type="checkbox"/> No <input type="checkbox"/> Yes BOX 6: TANF/SSI/Foster/Kinship/Sub <input type="checkbox"/>
	Are you or a member of your family currently receiving SSI? <input type="checkbox"/> No <input type="checkbox"/> Yes Preschool; 900 OR EHS; 150 <input type="checkbox"/>
	If yes, who: _____ Relationship to applicant: BOX 7: Homeless; all models 950 <input type="checkbox"/>
	Is this application for a child in Foster care? <input type="checkbox"/> No <input type="checkbox"/> Yes Kinship care? <input type="checkbox"/> No <input type="checkbox"/> Yes (FS/FA see App. Proc. <input type="checkbox"/>
	Are you currently experiencing homelessness? <input type="checkbox"/> No <input type="checkbox"/> Yes for add'l explanation) <input type="checkbox"/>
	Is the child's family currently receiving Child Protective Services (CPS) or similar Indian Child Welfare (ICW) services? <input type="checkbox"/> No <input type="checkbox"/> Yes BOX 8: CPS/FAR; 50 <input type="checkbox"/>
	Is the child's family currently receiving services from Family Assessment Response (FAR)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
Household income for the last calendar year or the last 12 months: BOX 9: Risk Factor Pts for Income; FPL Chart <input type="checkbox"/>	
Number of people in your household: _____ List ages of children: _____ <input type="checkbox"/>	

Section C: Health and Development Information

Child's Information	Has your child been DIAGNOSED by a Health Care Provider with any of the conditions listed below? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	If yes, check all that apply: <input type="checkbox"/> Respiratory (Asthma, RSV, RAD, other) 6 <input type="checkbox"/> Diabetes 6 <input type="checkbox"/> Seizures 6 <input type="checkbox"/> Heart Condition 6 <input type="checkbox"/> Food Allergies (list): 6 _____ <input type="checkbox"/> Swallowing 2 <input type="checkbox"/> Non-Food Allergies (list): 2 _____ <input type="checkbox"/> Other (list): 6 (Per guidance on Pointing Chart) <input type="checkbox"/>
	Do you have any other concerns about your child's health? <input type="checkbox"/> No <input type="checkbox"/> Yes BOX 11: Sub-section TOTAL <input type="checkbox"/>
	If yes, check all that apply: <input type="checkbox"/> Feeding and/or special diet 2 <input type="checkbox"/> Low birth weight (5.5lbs or less) 2 <input type="checkbox"/> Hearing 2 <input type="checkbox"/> Tooth Pain/Decay/Bleeding Gums 2 <input type="checkbox"/> Vision 2 <input type="checkbox"/> Mental Health 5 <input type="checkbox"/> Drug/Alcohol Affected 6 <input type="checkbox"/> Food Intolerance (list): 6 _____ <input type="checkbox"/> Other health concerns(list): 6 _____ <input type="checkbox"/>
	Does your child have medical insurance? <input type="checkbox"/> No 2 <input type="checkbox"/> Yes BOX 12: 2 pts possible <input type="checkbox"/>
	If yes, what type: <input type="checkbox"/> Apple Health/ProviderOne <input type="checkbox"/> Private <input type="checkbox"/> Indian Health <input type="checkbox"/> Other: _____ <input type="checkbox"/>
	Does your child have dental insurance? <input type="checkbox"/> No 2 <input type="checkbox"/> Yes BOX 13: 2 pts possible (unless gave 2 for No Med above) <input type="checkbox"/>
	If yes, what type: <input type="checkbox"/> Apple Health/ProviderOne <input type="checkbox"/> Private <input type="checkbox"/> Indian Health <input type="checkbox"/> Other: _____ <input type="checkbox"/>
	Has your child experienced (Check all that apply): BOX 14: Sub-section TOTAL <input type="checkbox"/>
	<input type="checkbox"/> Abuse/Neglect 6 <input type="checkbox"/> Former Foster Care 6 <input type="checkbox"/> Asked to leave a childcare center because of behavior 6 <input type="checkbox"/>
Does your child have a special need? (Check all that apply): <input type="checkbox"/> Individualized Family Service Plan (IFSP) <input type="checkbox"/>	
<input type="checkbox"/> Individualized Education Plan (IEP) Start Date: _____ End Date: _____ <input type="checkbox"/> A diagnosed disability <input type="checkbox"/>	
<input type="checkbox"/> Enrollment in an Early Intervention Birth to 3 program in the last 6 months BOX 15: Special Needs; 50 <input type="checkbox"/>	
Do you have concerns about your child's development? <input type="checkbox"/> No <input type="checkbox"/> Yes BOX 16: Sub-section TOTAL <input type="checkbox"/>	
If yes, check all that apply: <input type="checkbox"/> Speech/Talking (making sounds, delayed talking, hard to understand and/or difficulties understanding others) 2 <input type="checkbox"/> Fine Motor (grasping, drawing, writing and/or dressing) 2 <input type="checkbox"/> Behavior (hitting, biting, having tantrums and/or not cooperating) 6 <input type="checkbox"/> Gross Motor (walking, climbing, throwing, spinning, lack of eye contact, loss of skills) 2 <input type="checkbox"/> Other concerns: 2 _____ <input type="checkbox"/>	

Section D: Family Information

Child lives with: <input type="checkbox"/> One parent/guardian <input type="checkbox"/> Two parents/guardians BOX 17: One parent/guardian; 2	
Parent(s)/Guardian(s) Relationship to the applicant: <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Biological/Adoptive Parent(s) <input type="checkbox"/> Step Parent(s) <input type="checkbox"/> Other:	
Parent/Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	Parent/Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other
Name: _____	Name: _____
Address – if different than child: _____	Address – if different than child: BOX 18: Current teen parent 2 pts TOTAL
Are you a teen parent? <input type="checkbox"/> Yes 2 or 0 <input type="checkbox"/> No	Are you a teen parent? <input type="checkbox"/> Yes 2 or 0 <input type="checkbox"/> No
Primary Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message	Primary Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message
Secondary Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message	Secondary Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message
Email Address: _____	Email Address: _____
Date of birth: _____ / _____ / _____ Month Day Year	Date of birth: _____ / _____ / _____ Month Day Year
Is parent/guardian in active U.S. military duty? <input type="checkbox"/> No <input type="checkbox"/> Yes Is parent guardian a U.S. military veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes Is parent/guardian in job training or school? <input type="checkbox"/> No <input type="checkbox"/> Yes Is parent/guardian employed? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired <input type="checkbox"/> Disabled If employed, how many hours a week? _____	Is parent/guardian in active U.S. military duty? <input type="checkbox"/> No <input type="checkbox"/> Yes Is parent guardian a U.S. military veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes Is parent/guardian in job training or school? <input type="checkbox"/> No <input type="checkbox"/> Yes Is parent/guardian employed? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Retired <input type="checkbox"/> Disabled If employed, how many hours a week? _____
Do you need an interpreter? <input type="checkbox"/> No <input type="checkbox"/> Yes 4 or 0 What language(s) do you speak? _____	Do you need an interpreter? <input type="checkbox"/> No <input type="checkbox"/> Yes BOX 19: 4 pts TOTAL What language(s) do you speak? BOX 20: ELL 3 (if no DLL pts)
Education Level (check highest completed) <input type="checkbox"/> Grade 6 or less <input type="checkbox"/> High School Graduate <input type="checkbox"/> Grade 7 <input type="checkbox"/> College/Adv. Training <input type="checkbox"/> Grade 8 <input type="checkbox"/> College Degree/Training Certificate <input type="checkbox"/> Grade 9 <input type="checkbox"/> Associate Degree <input type="checkbox"/> Grade 10 <input type="checkbox"/> Bachelor Degree <input type="checkbox"/> Grade 11 <input type="checkbox"/> Master's Degree <input type="checkbox"/> Grade 12 (No diploma) <input type="checkbox"/> GED	Education Level (check highest completed) <input type="checkbox"/> Grade 6 or less <input type="checkbox"/> High School Graduate <input type="checkbox"/> Grade 7 <input type="checkbox"/> College/Adv. Training <input type="checkbox"/> Grade 8 <input type="checkbox"/> College Degree/Training Certificate <input type="checkbox"/> Grade 9 <input type="checkbox"/> Associate Degree <input type="checkbox"/> Grade 10 <input type="checkbox"/> Bachelor Degree <input type="checkbox"/> Grade 11 <input type="checkbox"/> Master's Degree <input type="checkbox"/> Grade 12 (No diploma) BOX 21: Less than 7th grade; 6 7th – 12th grade/GED; 5 <input type="checkbox"/> GED
To best support your family, please check all areas of concern you have for yourself and/or your family? <input type="checkbox"/> Disability/Unable to work 3 <input type="checkbox"/> Job/Employment 2 <input type="checkbox"/> Little or no support from family or friends 5 <input type="checkbox"/> Drug/Alcohol issues 5 <input type="checkbox"/> Learning difficulties 3 <input type="checkbox"/> Immigrant/Refugee (past 3 years) 15 <input type="checkbox"/> Health Concern 4 <input type="checkbox"/> Medical coverage 2 <input type="checkbox"/> Loss/Grief 3 <input type="checkbox"/> Incarcerated Parent(s) 6 <input type="checkbox"/> Family Violence 6 <input type="checkbox"/> Housing 4 <input type="checkbox"/> Legal issues 2 <input type="checkbox"/> Military deployment (current or in last year) <input type="checkbox"/> Immigration 3 <input type="checkbox"/> Mental Health, Post-Partum Depression, Anxiety, Depression, PTSD 4 <input type="checkbox"/> Past CPS Involvement 6 <input type="checkbox"/> Homeless in the past 12 months (not currently) 5 BOX 22: Sub-section TOTAL	
How did you hear about our program? BOX 23: 4 (Refer to Category and Risk Factor Pointing Chart for list of agencies) <input type="checkbox"/> Agency referral from: 4 _____ <input type="checkbox"/> Other: 0 _____	

I have answered the questions to the best of my knowledge. The information provided will be used to determine my child's eligibility for the Early Learning Programs. The information on your application is confidential and used ONLY to determine eligibility. We do not release information to immigration or other government authorities.

Parent/Guardian Signature: _____ Date: _____

STAFF ONLY	STAFF ONLY	STAFF ONLY	STAFF ONLY
Date received: _____ Date sent to PSESD: _____ Site ID/Name: _____	Child's Name: (Refer to Category and Risk Factor Pointing Chart) <input type="checkbox"/> This child is currently enrolled in a community slot at this center <input type="checkbox"/> This child's sibling is currently enrolled in a community slot at this center	Date FSS contacted family to review Application: BOX 24: Preschool; 800 OR EHS; 125	

