



Easter Seals Angle Lake  
4040 S. 188<sup>th</sup> St. Suite 101  
Seatac, WA 98188  
Office: (206) 816-3228  
Fax: (206) 971-5092

Greetings,

We are recruiting for our 2020-2021 school year. We are a full day, full year Early Head Start and Head Start program. The center is open 6:30 am to 6 pm Monday through Friday. As the attached flyer states we serve children 1-5 years old.

To complete an application you will need to:

1. Request an application by email ([slarrison@wa.easterseals.com](mailto:slarrison@wa.easterseals.com)) or calling 206-816-3228.
2. Provide: Proof of income (W2, Tax return, award letters)
3. Provide: Proof of household size (rental lease, tax return)
4. Provide: Proof of child's birth (birth certificate, passport, shot record)
5. Provide :Proof of guardianship (birth certificate, foster or adoption paperwork)
6. Completed Application

\*Once these documents have been received either by mail, email or fax (206-971-5092) the application will be processed and if approved the app will be placed on our waitlist. Acceptance is based on income and age. Please check in occasionally to let us know you are still interested and give us up to date contact information. To be considered for the 20-21 school year applications must be received by 8/14/20. Please contact me for help as needed at the phone or email above.

Lastly you will need to qualify for DCYF Child Care Subsidy; to contact them either:

Visit the Washington Connection website or  
Call the DCYF, Child Care Subsidy Contact Center at 1-844-626-8687

When you call have the:

Name and phone number of your child care provider available.

We are Easterseals, Provider # 826617, ph. 206-816-3255

Thank you for your time and if this is the program for you we hope to hear from you soon.

Warm Regards,  
Shirley

Shirley Larrison, Family Advocate  
Easterseals, Angle Lake  
4040 S. 188th St. Ste 101  
Seatac, WA 98188-5070  
206-816-3228

# Early Learning Application 2020-2021

## Child Information – General

First Name:	Middle Initial:	Last Name:
Date of Birth (month/day/year):		Gender: <input type="checkbox"/> M <input type="checkbox"/> F

What is this child's home language?	2 <sup>nd</sup> language:
Does this child speak: <input type="checkbox"/> Only English <input type="checkbox"/> Mostly English and another language <input type="checkbox"/> Some English, but mostly another language <input type="checkbox"/> Both English and another language the same (bilingual) <input type="checkbox"/> Only a language other than English	

Is this child Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is this child's race? Check all that apply: <input type="checkbox"/> African/African American/Black <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Alaska Native/Native American/American Indian <input type="checkbox"/> Not listed above:
What is your family's heritage/tribe/country of origin?

Has this child previously attended these programs? Only check the <b>most recent</b> : <input type="checkbox"/> None <input type="checkbox"/> Head Start/Early Head Start/ECEAP in King or Pierce County, Washington State <input type="checkbox"/> Migrant/Seasonal Head Start anywhere in Washington State <input type="checkbox"/> Early Support for Infants and Toddlers (ESIT) or any Birth-to-Three/Home Visiting program <input type="checkbox"/> Head Start/Early Head Start/ECEAP in another Washington State County
When did this child last attend? Name and location of program:
Is this child currently enrolled in a community slot at this site? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is this child a <b>sibling</b> of a currently enrolled child at this site? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>The questions below are for information only. Answering "Yes" will not affect your eligibility or enrollment in the program.</b>
Is this child in official foster care or kinship care <b>with</b> a grant amount? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, what is the Case Number or Client ID Number?</b> What is the monthly grant/payment amount and source? \$ <input type="checkbox"/> DSHS <input type="checkbox"/> SSI <input type="checkbox"/> Tribe <input type="checkbox"/> Other # of children covered by grant amount:
Is this child in kinship care <b>without</b> a grant amount? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was this child adopted after foster care or kinship care? <input type="checkbox"/> Yes <input type="checkbox"/> No
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
Has your family received services from CPS/FAR/ICW in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your family currently approved for child care through CPS or FAR? <input type="checkbox"/> Yes – How many approved hours per week? <input type="checkbox"/> No
Has this child ever been asked to leave an early learning program because of behavior issues? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Child Information – Health

Does this child have medical insurance? ☐ Yes ☐ No

If yes, what type? ☐ Washington Apple Health/ProviderOne ☐ Private Insurance ☐ Tribal ☐ Military Medical Coverage

Does this child have a regular doctor or medical clinic?

☐ Yes - Name of clinic/provider:

Name of medical professional:

☐ No

Did this child have a well-child exam within the last 12 months?

☐ Yes – Date of last exam (month/day/year):

☐ No ☐ Date Unknown

What is your child's immunization status? ☐ Fully immunized ☐ Exempt ☐ Not fully immunized or exempt ☐ Not sure

Does this child have dental insurance? ☐ Yes ☐ No

If yes, what type? ☐ Washington Apple Health/ProviderOne ☐ Private Insurance ☐ Tribal ☐ ABCD ☐ Military Dental Coverage

Does this child have a regular dentist or dental clinic?

☐ Yes - Name of clinic/provider:

Name of dental professional:

☐ No

Did this child have dental exam within the last 6 months?

☐ Yes – Date of last exam (month/day/year):

☐ No ☐ Date Unknown

Has this child been diagnosed by a Health Care Provider with a chronic health condition (may include asthma, cancer, diabetes, seizures, ADHD, autism, spina bifida, sickle cell disease, or life-threatening allergies)?

☐ Yes – Please describe:

The health condition is considered: ☐ Severe ☐ Moderate ☐ Mild

☐ No

## Child Information - Development

Do you have concerns about this child's health? ☐ Yes – check all that apply below ☐ No

☐ Low birth weight (less than 5.5 lbs/5 lbs 8 oz.)

☐ Preterm birth less than 37 weeks

☐ Drug/alcohol affected

☐ Hearing

☐ Fine motor/gross motor

☐ Tooth pain/decay/bleeding gums

☐ Vision

☐ Food intolerance/special diet –

Please describe:

Does this child have a **current and active** Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?

☐ Yes – Please provide a copy with your application.

☐ No – Check if any of these apply:

☐ My child has a diagnosed developmental delay or disability, has no IEP, or is being referred for evaluation.

☐ My child has a suspected developmental delay or disability.



## Parent/Guardian Information

This child lives with:

☐ One parent/guardian (complete Parent/Guardian 1)

☐ Two parents/guardians in the same household (complete Parent/Guardian 1 & 2)

☐ Two parents/guardians in two households (complete Parent/Guardian 1 & 2)

	Parent/Guardian 1	Parent/Guardian 2
Name		
Relationship to child	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other:	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other:
Gender	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Not specified	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Not specified
Date of Birth (month/day/year)		
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		
Were you under age 18 when this child was born?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
What language(s) do you speak?		
Do you need an interpreter for this language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your race? Check all that apply	<input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above:	<input type="checkbox"/> African/African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native/Native American/American Indian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not listed above:
What is the highest level of education you completed?	<input type="checkbox"/> 6 <sup>th</sup> grade or less <input type="checkbox"/> 7 <sup>th</sup> to 12 <sup>th</sup> grade, no diploma or GED <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's or doctorate degree <input type="checkbox"/> None	<input type="checkbox"/> 6 <sup>th</sup> grade or less <input type="checkbox"/> 7 <sup>th</sup> to 12 <sup>th</sup> grade, no diploma or GED <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's or doctorate degree <input type="checkbox"/> None

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	Parent/Guardian 1	Parent/Guardian 2
Are you currently employed?	<input type="checkbox"/> Yes – How many hours per week (including travel)?  Employer name & phone #:  <input type="checkbox"/> No <input type="checkbox"/> No, retired or disabled <input type="checkbox"/> Seasonal	<input type="checkbox"/> Yes – How many hours per week (including travel)?  Employer name & phone #:  <input type="checkbox"/> No <input type="checkbox"/> No, retired or disabled <input type="checkbox"/> Seasonal
Are you currently in job training or school?	<input type="checkbox"/> Yes – How many hours per week (including class time, study time, travel)?  School name & major/goal:  <input type="checkbox"/> No	<input type="checkbox"/> Yes – How many hours per week (including class time, study time, travel)?  School name & major/goal:  <input type="checkbox"/> No
Are you in an approved WorkFirst activity?	<input type="checkbox"/> Yes – Describe the activity and the number of approved hours per week: <input type="checkbox"/> No	<input type="checkbox"/> Yes – Describe the activity and the number of approved hours per week: <input type="checkbox"/> No
Are you or have been in the U.S. military?	<input type="checkbox"/> Yes, current service member <input type="checkbox"/> Yes, currently deployed or have been in the last 12 months/for a total of 19 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No	<input type="checkbox"/> Yes, current service member <input type="checkbox"/> Yes, currently deployed or have been in the last 12 months/for a total of 19 months <input type="checkbox"/> Yes, veteran <input type="checkbox"/> No

## Family Concerns

Please check areas of concern that you have for yourself/family in your household:

<input type="checkbox"/> Child's parent/guardian has a disability or is chronically ill and is: <input type="checkbox"/> Unable to engage in work/school/family life <input type="checkbox"/> Somewhat able to engage in work/school/ family life <input type="checkbox"/> Mostly able to engage in work/school/family life <input type="checkbox"/> Child's parent/guardian has learning difficulties, no disability	<input type="checkbox"/> Household mental illness, including maternal depression (child is diagnosed, or adult is experiencing) <input type="checkbox"/> Household domestic violence (past or current) <input type="checkbox"/> Household drug/alcohol issues or substance abuse (past or current) <input type="checkbox"/> Family is socially isolated, with complete or near-complete lack of contact with others <input type="checkbox"/> Getting or keeping a job	<input type="checkbox"/> Legal concerns <input type="checkbox"/> Child's parent/guardian is a migrant worker <input type="checkbox"/> Recent immigrant/refugee (past 5 years) <input type="checkbox"/> Child's parent/guardian is incarcerated <input type="checkbox"/> Loss of a parent (death, abandonment, or deportation) <input type="checkbox"/> Child's parents/guardians divorced or separated during child's life <input type="checkbox"/> Previously homeless (in the last 12 months) <input type="checkbox"/> Concerns with housing
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## Family Living Situation

Does this household receive subsidized housing such as a housing voucher or cash assistance for housing? ☐ Yes ☐ No

What is your family's current housing situation? **The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. Your answers may help us determine the services your child may be eligible to receive.**

<input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> In someone else's house or apartment with another family: ➢ <input type="checkbox"/> By choice (e.g. to save money, to be close to family, etc.) ➢ <input type="checkbox"/> Due to loss of housing, economic hardship, or similar reason	<input type="checkbox"/> In a motel <input type="checkbox"/> In a shelter <input type="checkbox"/> A car, park, campsite, or similar location <input type="checkbox"/> Transitional Housing	<input type="checkbox"/> Moving from place to place/couch surfing <input type="checkbox"/> In a residence with inadequate facilities (no water, heat, electricity) <input type="checkbox"/> Other – Please describe:
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# Early Learning Application 2020-2021

## Family Income and Family Size

Check all that apply if you, this child, or another person living in your home related to you by blood, marriage, or adoption receive these types of Public Assistance:

- ☐ SSI for disability received by: ☐ Child ☐ Parent/Guardian ☐ Other – Relationship to child:  
☐ Temporary Assistance for Needy Families (TANF) cash.

Check if you also have the following: ☐ Child-only TANF ☐ WorkFirst ☐ Working Connections Child Care subsidy

Please list additional people living in this child's primary household below, not including yourself or this child.

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
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			<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

What is the **total number** of family members living in your home, including yourself and this child?

What is your **total estimated** household income for the last calendar year or the last 12 months?

I promise that the information on this form is true and correct. I have reported all my income and family size, as required by the Early Learning Programs. If I knowingly provide false information, I understand my family may be unable to continue program services. Additionally, if my child is enrolled in ECEAP, I may have to repay the amount spent on my child.

I understand that information from this application is entered in various Early Learning databases operated by the Department of Children, Youth, and Families (DCYF) and Puget Sound Educational Service District (PSESD). DCYF and PSESD are committed to protecting confidential and personal information that could identify a child or family. No information related to immigration status is entered in the databases or shared with state or federal agencies. Information in the databases may be used for the following:

- Research studies to determine if participating in Early Learning 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.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

(ECEAP Staff: Enter this date in ELMS)

**\*Staff Only – If not signed, complete below. Parent signature must be obtained as soon as possible, or no later than the enrollment visit.**

Reviewed and received verbal verification on (date):

Staff Initials:

(ECEAP Staff: Enter this date in ELMS if not signed – you cannot update this once the ELMS application is locked)

Staff Only



Washington State Department of  
CHILDREN, YOUTH & FAMILIES

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Language: English

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Child's Age:	Total Verified Family Size:	Total Verified Income:	Total Points:
Site Name/ID:		Date received: (This date will determine eligibility timeframe)	
Date staff reviewed application with family:		Date sent to PSED (N/A for ECEAP only sites):	
EHS Only - Is this child a newborn taking the mother's slot? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, mother's name:			
For Homeless Families – 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"/> Immunization/medical records	<input type="checkbox"/> Medicaid/DSHS services – Food stamps/TANF	
<input type="checkbox"/> Clothing resources	<input type="checkbox"/> Vision referral	<input type="checkbox"/> College/vocational/technical resources	
<input type="checkbox"/> School supplies	<input type="checkbox"/> Hygiene products/toiletries	<input type="checkbox"/> School transportation (if site provides)	
<input type="checkbox"/> Medical/dental referral	<input type="checkbox"/> Food resources	<input type="checkbox"/> Other:	
<input type="checkbox"/> Housing/shelter referral	<input type="checkbox"/> Birth certificate		
Staff Name & Signature:		Date:	