

## 2026-2027 SVC ECEAP PRESCHOOL APPLICATION

If you need help completing this form, please contact: 360-679-5348 /eceap.enrollment@skagit.edu

### Section 1: Child Information

Legal first name \_\_\_\_\_

Middle name \_\_\_\_\_

Legal last name \_\_\_\_\_

Nickname \_\_\_\_\_

Date of birth \_\_\_\_\_

Gender identity \_\_\_\_\_

Is this child a member, or eligible for membership, of a Federally Recognized Tribe of the United States?

Yes  No

### General Information

**IEP** - Is this child on an Individualized Education Program (IEP)? .....  Yes  No

**CPS** - Is this child's family actively involved in and/or receiving support from Tribal or State Systems including Child Protective Services (CPS), Family Assessment Response (FAR), Indian Child Welfare (ICW), comparable tribal services or Law Enforcement/court system regarding child abuse, neglect, or sexual assault? .....  Yes  No

**Foster Care** - Is this child in official foster care? *This means there is a caregiver authorization from a state or tribe that says this is a foster care placement* .....  Yes  No

**Kinship** - Is this child in kinship care with a relative or suitable other, with or without a grant? .....  Yes  No

**Adopted after foster/kinship care** - Was this child adopted after foster care, kinship care, or after living in an orphanage in another country? *This does not include other adoptions* .  Yes  No

## Language

Child's first language\_\_\_\_\_

Child's second language\_\_\_\_\_

This child speaks (*Select one*)

- Only English
- Mostly English, and some of another home language
- English and another language at age level (bilingual)
- Some English, but mostly another home language
- Only a home language other than English

## Housing

(*Select one*)

- Rent or own an adequate residence
- Doubled up in a cooperative living arrangement with relatives or friends
- Doubled up with another family due to loss of housing, economic hardship, or a similar reason
- In an emergency or transitional shelter
- Sleeping in a hotel, motel, car, park, campsite, or similar location
- Moving from place to place (couch surfing)
- Inadequate housing such as no water, heat or electricity; excessive mold; or no cooking facilities

## Race and Ethnicity

What race(s) and ethnicities do you consider this child? *(Check all that apply)*

Decline to report child's race  Decline to report child's ethnicity

White  Black or African American

Hispanic/Latino

Argentinian

Bolivian

Chilean

Colombian

Costa Rican

Cuban

Dominican

Ecuatorian (Ecuadorian)

Guatemalan

Honduran

Mexican or Mexican-American  
(Chicano)

Nicaraguan

Panamanian

Peruvian

Puerto Rican

Salvadoran

Spanish

Uruguayan

Venezuelan

Latin American

Other *Hispanic or Latino*

---

Alaska Native

Aleut (Unangan)

Alutiiq

Athabaskan

Eskimo (Inupiaq or Yupik)

Eyak

Haida

Tlingit

Tsimshian

Other Alaska Native

---

Asian

Asian Indian

Bangladeshi

Bhutanese

Burmese

Cambodian/Kampuchean

Chinese

Filipino

Hmong

Indonesian

Japanese

Korean

Laotian

Madagascar

Malayan

Maldivian

Mongolian

Nepali

Pakistani

Singaporean

Sri Lankan

Taiwanese

Thai

Vietnamese

Other Asian \_\_\_\_\_

American Indian

Chehalis

Chinook

Colville

Cowlitz

Duwamish

Hoh

Jamestown

Kalispel

Kikiallus

Lower Elwha

Lummi

Makah

Muckleshoot

Nisqually

Nooksack

Port Gamble Klallam

Puyallup

Quileute

Quinault

Samish

Sauk-Suiattle

Shoalwater

Skokomish

Snohomish

Snoqualmie

Snoqualmoo

Spokane

Squaxin Island

Steilacoom

Stillaguamish

Suquamish

Swinomish

Tulalip

Upper Skagit

Yakama

Other American Indian

---

Native Hawaiian or Other Pacific

Fijian

Guamanian

Kosraean

Mariana Islander

Marshall Islander

Melanesian

Micronesian

Native Hawaiian

Palauan

Papua New Guinean

Ponapean (Pohnpeian)

Samoan

Solomon Islander

Tahitian

Tarawa Islander

Tokelauan

Tongan

Trukese (Chuukese)

Vanuatuan/New Hebrides

Yapese

Other Pacific Islander

---

## Section 2: Household Members

- Please list everyone living in the household who may be counted in the 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 State Median Income (SMI)**

First and 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	Yes	Yes
		Parent/ Guardian_1	Yes	Yes
		Parent/ Guardian_2	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 their expenses.*

### For staff use only

Family size for SMI chart \_\_\_\_\_

- For children in foster care, kinship, or adopted after foster or kinship care, count family size as 1.
- For all others, count people with Yes for both questions above.

### Section 3: Family Contact Information

#### Contact 1

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Do you need an interpreter to communicate with English speakers?  Yes  No

If yes, what language(s) do you speak? \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State **WA** ZIP Code \_\_\_\_\_  
(Physical Address)

Address \_\_\_\_\_ City \_\_\_\_\_ State **WA** ZIP Code \_\_\_\_\_  
(Mailing Address if different than physical address)

Email \_\_\_\_\_ Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

#### Contact 2

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Relationship to Child \_\_\_\_\_

#### Contact 3

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Relationship to Child \_\_\_\_\_

### Section 4: Child lives with

One parent/guardian (Name) \_\_\_\_\_ (Skip to section 5 if one parent)

Two parents/guardians in same household

Parent/guardian name 1 \_\_\_\_\_

Parent/guardian name 2 \_\_\_\_\_

Two parents/guardians in two households

If this is checked, answer these questions to determine which parents' income is counted for ECEAP eligibility.

Does one household have primary legal custody?  Yes  No

If yes, which parent has primary custody? \_\_\_\_\_

Spouse of this parent, if any \_\_\_\_\_ (Skip to section 5)

If **no**, ECEAP will count the income from the legal parent/guardian for each household. Do not include their spouses. Enter the legal parents' names here:

Household 1 \_\_\_\_\_ Household 2 \_\_\_\_\_

**Household 2**

Relationship with child \_\_\_\_\_

Do you need an interpreter to communicate with English speakers?  Yes  No

If yes, what language(s) do you speak?

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
(Physical Address)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
(Mailing Address if different than physical address)

Email \_\_\_\_\_ Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**Section 5: Parent Employment, Training, and Other Activities**

- Answer the following questions for each parent/guardian listed in question #3.
- Do not count the same hours in more than one category. For example:
  - Do not count the same hours of the week in both employment and WorkFirst.
  - Do not count the same CPS child care hours separately for two parents

**Parent/Guardian # 1**

Name \_\_\_\_\_ Employed  Yes  No (if yes answer the following)

Name of employer (don't enter unknown or N/A) \_\_\_\_\_

Average paid hours per week \_\_\_\_\_

In school or job training  Yes  No (if yes answer the following)

Class hours per week \_\_\_\_\_ Study hours per week (maximum 10) \_\_\_\_\_

Name of school or training organization \_\_\_\_\_

Goal or major \_\_\_\_\_

Travel between child care and work/school  Yes  No Hours per week (maximum 10) \_\_\_\_\_

CPS/FAR/ICW child care hours not counted above  Yes  No

Additional hours per week of child care approved by CPS) \_\_\_\_\_

Approved WorkFirst hours not counted above \_\_\_\_\_

Name of activity \_\_\_\_\_ Total hours per week \_\_\_\_\_

Disabled parent unable to work and unable to care for the child while the other parent works  Yes  No

If either parent has more than 55 hours total per week, explain:

**Parent/Guardian # 2**

Name \_\_\_\_\_ Employed  Yes  No (if yes answer the following)

Name of employer (don't enter unknown or N/A) \_\_\_\_\_

Average paid hours per week \_\_\_\_\_

In school or job training  Yes  No (if yes answer the following)

Class hours per week \_\_\_\_\_ Study hours per week (maximum 10) \_\_\_\_\_

Name of school or training organization \_\_\_\_\_

Goal or major \_\_\_\_\_

Travel between child care and work/school  Yes  No Hours per week (maximum 10) \_\_\_\_\_

CPS/FAR/ICW child care hours not counted above  Yes  No

Additional hours per week of child care approved by CPS) \_\_\_\_\_

Approved WorkFirst hours not counted above \_\_\_\_\_

Name of activity \_\_\_\_\_ Total hours per week \_\_\_\_\_

Disabled parent unable to work and unable to care for the child while the other parent works  Yes  No

If either parent has more than 55 hours total per week, explain:

**Section 6: How did you find out about ECEAP**

- DCYF website
- Community event
- Flyer
- ECEAP employee
- Word of mouth
- Caseworker
- Media
- Community agency - Name of agency \_\_\_\_\_
- Other \_\_\_\_\_

**Section 7: Survey for Statewide Planning**

If you could choose the length of day for your child's preschool, which would be best for your child and family?

*Please note, these options may not all be available in your community this year.*

- Part Day – about 3 hours, 3 or 4 days a week.  School Day – about 6 hours, 4 or 5 days a week.
- Working Day – available all day, all year, like a child care center.

**Section 8: 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

**Section 9: Income Received by Child's Parent(s) or Guardian(s)**

❖ **For children in foster care, kinship care, or adopted after foster or kinship care:**

please enter the case number \_\_\_\_\_ (if none write none and skip to Section 10)

- Did you receive income during the last calendar year or during the previous 12 months?  Yes  No
- If no, provide the reason there is no income. Explain how basic needs are met.

**Enter all family income for one year in the chart below.**

Select one  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			\$		\$
	State or Tribal TANF Grants			\$		\$
	Unemployment	\$				\$
	Workers Compensation (L&I)	\$				\$
	Tribal income (taxable)					\$
	Emergency Assistance Cash Payments			\$		\$
	Insurance Payments that are regular (not 1 time)			\$		\$
	Retirement or pension plans					
	Training Stipend					
	Scholarship, Grants, or Fellowships for living expenses					
<b>Subtract</b>	Child support paid to another household, if required by a legally-binding child support order			\$		\$
					<b>Total</b>	

Do you still receive the income above?  Yes  No If yes, skip to section 10

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

- Loss of wage earner
- Divorce or separation
- Reduced work hours
- Health/Injury
- Loss of benefits
- Job loss – lack of access or ability to afford child care for newborn
- Similar unexpected circumstance (explain)

What is your monthly income? \$ \_\_\_\_\_ For which month? \$ \_\_\_\_\_

## Section 10: Previous Enrollment

This child was previously enrolled in: *(check all that apply)*

- Head Start at your agency
- Head Start with a different agency
- Migrant/Seasonal Head Start anywhere in WA
- Early Head Start Name of EHS Grantee \_\_\_\_\_
- Any birth to three home visiting program
- Early ECEAP Name of Early ECEAP contractor \_\_\_\_\_
- ECLIPSE - Early Childhood Intervention and Prevention Services
- ESIT – Early Support or Infants Name of ESIT Provider \_\_\_\_\_
- Part C Part C IDEA Early Intervention program in another state State \_\_\_\_\_  
Name of provider \_\_\_\_\_
- No previous early learning preschool enrollment

## Section 11: IEP or Suspected Delay

*(Check one if applicable)*

- This child has an Individualized Education Program (IEP)
- This child was determined eligible for special education services through evaluation by a school district or tribal school but waiting for IEP to be issued or parent/guardian declined services.
- This child has a diagnosed developmental delay or disability with no IEP.
- This child completed a developmental screening that recommended referral for further evaluation
- This child has a suspected developmental delay or disability.

*(No IEP, diagnosis, or screening, or completed developmental screening with result, "rescreen needed".)*

Please describe.

**If this child has an IEP check all categories of the IEP. If not, [skip to Section 12.](#)**

- |  |  |   |
|--|--|---|
| <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 or language           |
| <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    | _____  |   |

IEP Start Date \_\_\_\_\_ IEP End Date \_\_\_\_\_

What school district issued this child's IEP \_\_\_\_\_

This child will receive IEP services:

- Within the ECEAP classroom only
- During ECEAP hours only, but outside the ECEAP classroom
- Outside ECEAP hours

## Section 12: Behavior

Has this child been expelled from any early learning program or child care due to behavior?  Yes  No

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

## Section 13: Additional Questions

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

Does this child have a household family member who has a chronic physical or mental health condition that.....  Yes  No

*(if yes select one)*

Severely impacts their ability to engage in work, school, or family life?

Moderately impacts their ability to engage in work, school, or family life?

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 or seasonal agricultural worker?.....  Yes  No

Does this child have a parent who moves with child to engage in traditional cultural practices or employment (seasonal or temporary in agricultural or fishing work)?.....  Yes  No

Does this child have a military parent deployed currently, or within the past 12 months, or for a total of 19 or more months within the child's lifetime?.....  Yes  No

Does this child have a family who attended an Indian boarding school?.....  Yes  No

Has this child experienced a parent incarcerated, such as in jail or prison?.....  Yes  No

Has this child experienced the loss of a parent or primary caregiver such as by death or abandonment?.....  Yes  No

Has this child experienced the divorce or separation of their parents?.....  Yes  No

Has this child experienced homelessness within the last 12 months?.....  Yes  No

Has this child lived in a household with domestic violence, including in-utero?.....  Yes  No

Has this child lived in a household with substance abuse, including in-utero?.....  Yes  No

Has this family previously received support or been involved in tribal or state systems including CPS/FAR/ICW services, or comparable tribal service, or been involved with law enforcement/court system regarding child abuse, neglect, or sexual assault?.....  Yes  No

Has this child been reunited with parents after foster or kinship care in the past 12 months?.....  Yes  No

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

**Section 14: Parent Education Level**

*(select the highest level of education)*

**Parent/Guardian 1 Name** \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> 6th grade or less                                      | <input type="checkbox"/> 7th to 12th grade, no diploma or GED |
| <input type="checkbox"/> High school diploma or GED                             | <input type="checkbox"/> Some college                         |
| <input type="checkbox"/> Professional certificate (includes vocational schools) | <input type="checkbox"/> Associate degree                     |
| <input type="checkbox"/> Bachelor's degree                                      | <input type="checkbox"/> Master's degree or doctorate         |

**Parent/Guardian 2 Name** \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> 6th grade or less                                      | <input type="checkbox"/> 7th to 12th grade, no diploma or GED |
| <input type="checkbox"/> High school diploma or GED                             | <input type="checkbox"/> Some college                         |
| <input type="checkbox"/> Professional certificate (includes vocational schools) | <input type="checkbox"/> Associate degree                     |
| <input type="checkbox"/> Bachelor's degree                                      | <input type="checkbox"/> Master's degree or doctorate         |

**Section 15: Health Information**

*Please attach a copy of the child's immunization record*

Does this child have a chronic physical or mental health condition that:.....  Yes  No

- Severely impacts child development or attendance?
- Moderately impacts child development or attendance?

If yes, please describe

Was this child born preterm (less than 37 weeks), or weigh less than 5.5 pounds at birth? .....  Yes  No

Does this child have medical insurance or coverage?

- |   |  |
|---|--|
| <input type="checkbox"/> Washington Apple Health for Kids/ Provider One Services Card | <input type="checkbox"/> Military Coverage |
| <input type="checkbox"/> Private Medical Insurance                                    | <input type="checkbox"/> Tribal Coverage   |

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

Has ECEAP received a copy of the results for a well-child (EPSDT) exam?.....  Yes  No

Date of last well-child exam before applying for ECEAP \_\_\_\_\_

Does this child have dental insurance or coverage?

- |   |   |
|---|---|
| <input type="checkbox"/> Washington Apple Health for Kids/ Provider One Services Card | <input type="checkbox"/> Private Dental Insurance             |
| <input type="checkbox"/> Military Coverage  | <input type="checkbox"/> Tribal Coverage                      |
|   | <input type="checkbox"/> ABCD (not available in all counties) |

Does this child have a regular doctor or dental clinic? .....  Yes  No

Has ECEAP received a copy of the results for a dental screening? .....  Yes  No

Date of last dental screening before applying for ECEAP \_\_\_\_\_

### Signature of Parent/Guardian

I promise that the information on this form is true and correct. I have authority to enroll this child and have reported all my income and family size, as required by ECEAP. If I knowingly provide false information, I understand my family may be unable to continue ECEAP services. Additionally, I may have to repay the amount spent on my child's ECEAP.

I understand that information from this application is entered in the Early Learning Management System (ELMS) operated by the Department of Children, Youth, and Families (DCYF). DCYF is committed to protecting confidential and personal information that could identify a child or family. No information related to immigration status is entered into ELMS or shared with state or federal agencies. Information in ELMS may be used for:

- Research studies to determine if participating in ECEAP 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.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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 Children, Youth, and Families 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.  
Services that were not actually provided.

Children's actual start dates and last days in class.  
A family providing false information in order to enroll in ECEAP.

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_