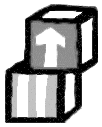
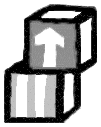


RELIABLE ENTERPRISES
LEWIS COUNTY HEAD START/ECEAP

Family Application



Child's Legal Name: *Last* *First* *MI* **Date of Birth:**

Ethnic Origin: ❑ American Indian/Alaskan Native ❑ Asian ❑ Bi-racial/Multi-racial ❑ Black/African American ❑ Hispanic/Latino ❑ Native Hawaiian/Pacific Islander ❑ Refused ❑ Unknown ❑ White ❑ Other

Gender: ❑ M ❑ F

Does child have a diagnosed or documented disability? ❑ **No** ❑ **Yes** Did child have either an ❑ **IEP** ❑ **IFSP**

Does child have a potential or suspected behavioral or developmental concern? ❑ **No** ❑ **Yes** (*Example: speech or emotional concern*)

Has child attended a special education/early intervention program? ❑ **No** ❑ **Yes**

Was child referred to program? ❑ **No** ❑ **Yes**, by whom why?

Child lives with: ❑One parent ❑Two parents ❑ Foster parent(s) ❑Other_____

Others living in household: ❑Adults & Children(ages)_____

Language(s) spoken at home: Interpreter needed for ❑ Parent ❑ Child

Does child have any **allergies?** ❑No ❑Yes ❑Food ❑Seasonal ❑Other _____

Does child take any **medications?** ❑No ❑Yes: If yes what does the child take and why?_____

Does child have **medical and dental insurance?** ❑No ❑Yes _____ Carrier?_____

Is child current on **Well Child Exam?** ❑No ❑Yes Date of last exam_____ Where?_____

Is child current on **Dental Exam?** ❑No ❑Yes Date of last exam_____ Where?_____

Is child current on **immunizations?** ❑No ❑Yes Please **provide copy of Certificate of immunizations with application**.

Does child attend daycare? ❑No ❑Yes Where?_____

Parent/Legal Guardian Name(s): Adult DOB:

Mailing Address: City: State: Zip:

Street Address/City *(if different):*

Home Phone: ( ) Message Phone: ( ) Who:

Other Phone (*cell, pager, work*): ( ) Who:

Has a child in the family been enrolled in the program before this year? ❑No ❑Yes What year?

How did you hear about Head Start?

Do any of the following apply to your family? (***Please check all that apply***):

❑ TANF (cash) ❑ SSI ❑ Foster Care ❑ Homeless ❑ CPS

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

If we are not selected for Lewis County Head Start I □give/□do not give permission for my name and phone number to be shared with Centralia Community College ECEAP Program.

Parent/Legal Guardian signature: **Date**: / /

• **APPLICATION INSTRUCTIONS ON BACK** ➳

Application Instructions:

- Answer all questions
- Print
- **ATTACH proof of your CHILD'S BIRTH** date using any one of the following:

  - ❑ Birth or Baptismal certificate
  - ❑ Immunization record
  - ❑ Immigration registration card
  - ❑ Two signed statements from **non-family** members

- **ATTACH proof of all your family's INCOME (before taxes)** for the most recent past 12 months or last calendar year. The following documents may be used as proof:

  - ❑ Income Tax Return
  - ❑ Employer letter
  - ❑ Social Security/SSI
  - ❑ Current Pay Stubs
  - ❑ DSHS/TANF - Grant benefit history
  - ❑ Statement of earnings (W-2 form)
  - ❑ Child Support
  - ❑ Unemployment Compensation
  - ❑ College/University scholarships, grants, fellowships
  - ❑ L&I/Workers Compensation (time loss)
  - ❑ Alimony

Applications cannot be processed until we receive proof of your child's date of birth and proof of your family income

- Did you **sign and date this application**? (Original documents will be returned upon request)

Completed applications may be mailed or delivered to:

LEWIS COUNTY HEAD START/ECEAP
1703 N Pearl
Centralia, WA 98531-5517

(360)736-1696

For Administrative Use Only

Income Documentation:	Birth date verified? **Y N**
Income amount:	# in family:
Eligibility Status:	

Eligible □Income Eligible □Categorically Eligible □**I**neligible (Over Income/Non-Categorically Eligible □**S**pecial Needs

Age	Income pts	Disability/Special Need	Referral	Categorically Eligible	Transfer	*Total pts*
3 yrs = 7 4 yrs = 15		L1 = 10 L2 = 5	8	15	100	

Comments:

Signature of verifying staff member Date / /