



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:

- ▶ 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:

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

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

LCHS does not discriminate against any person on the basis of race, color, national origin, disability or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: the LCHS Program Director, (360)736-1696, TDD/State Relay 1-800-833-6384.

For Administrative Use Only

Date / /		Signature of verifying staff member				
Comments:						
Total pts	Transfer 100	Categorically Eligible 15	Referral 8	Disability/Special Need L1 = 10 L2 = 5	Income pts	Age 3 yrs = 7 4 yrs = 15
Eligibility Status:						
Eligible <input type="checkbox"/> Income Eligible <input type="checkbox"/> Categorically Eligible <input type="checkbox"/> Ineligible (Over Income/Non-Categorically Eligible <input type="checkbox"/> Special Needs <input type="checkbox"/>						
# in family:			Income amount:			
Birth date verified? Y N			Income Documentation:			