



Early Head Start 2010-2011 Application

Denise Louie Education Center
 801 S Lane St.
 Seattle, WA 98104
 (206) 902-6410

Prenatal Information	<p>Complete the following if pregnant:</p> <p>Name: _____ Date of birth: _____</p> <p>Any difficulties with pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated due date: _____</p>
Child Information	<p>Child's Name (Last, First) _____ Date of birth: _____</p> <p>Gender: _____</p>
	<p>Home phone #: _____ Work #: _____</p>
	<p>Message #: _____ Name of Message Person: _____</p>
	<p>Home address: _____ (City/State/Zip)</p>
	<p>We are homeless. (This means your family is staying in a car, park, camp ground or hotel, emergency shelter or transitional housing or your family is living with another family temporarily.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>What language(s) does the child speak? _____</p>
	<p>Child's Ethnicity: Check One Box <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic</p>
	<p>Child's Race(s): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Biracial</p>
	<p>Do you have concerns for your child? <input type="checkbox"/> No <input type="checkbox"/> Yes Please check all that apply. <input type="checkbox"/> Dental Health <input type="checkbox"/> Learning Difficulties <input type="checkbox"/> Speech or Hearing <input type="checkbox"/> Behavior <input type="checkbox"/> Physical Health <input type="checkbox"/> Nutrition/Eating <input type="checkbox"/> Abuse/ Neglect <input type="checkbox"/> Vision <input type="checkbox"/> Former Foster Child/Foster Child in transition <input type="checkbox"/> Other _____</p>
	<p>Is this child on an IFSP/IEP (Special Education)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>Does this child have medical insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Health Plan: _____ <input type="checkbox"/> DSHS Coupon <input type="checkbox"/> Basic Health <input type="checkbox"/> Private <input type="checkbox"/> Other</p>
	<p>Does this child have dental insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Insurance: _____</p>

Family Information

Child lives with: One parent Two parent

Are you a teen parent? Yes No

Child is : Your natural (biological) or Adopted Child Foster Child Grandchild Other

Are there other children residing in the home (other than the applicant)? No Yes
 How many are 0-2.11 mo. _____ How many are 3-5yrs.? _____ How many are 6 yrs. and older?

Name of children	Gender (m/f)	Date of birth	Enrolled in HS/EHS?
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Do you have concerns for yourself or other family members? No Yes
 Please check all that apply:
 Housing Job/Employment Disability/Unable to work Family violence Learning difficulties
 Drug/Alcohol issues Immigration Mental Health Military deployment
 Legal issues Health issues Incarcerated parent Recent death in the family Terminal illness
 Other _____

Special Agency Referral:

Other adults living in the home? No Yes
 What is their financial contribution to the household?

<u>Name</u>	<u>Relationship to the child</u>
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Parent/Guardian 1	Parent/Guardian 2
Mother/Father/Other (please circle)	Mother/Father/Other (please circle)
Birth date: _____	Birth date: _____
Race/Ethnicity:	Race/Ethnicity:
Address(if different than the child)	Address(if different than the child)
Cell/home #	Cell/home #
Email Address:	Email Address:
Language you speak: Do you have medical/dental coverage? Do you require an interpreter to access services? <input type="checkbox"/> No <input type="checkbox"/> Yes	Language you speak: Do you have medical/dental coverage? Do you require an interpreter to access services? <input type="checkbox"/> No <input type="checkbox"/> Yes

Family Information	Education Level (check highest completed) <input type="checkbox"/> Grade 8 or less <input type="checkbox"/> Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade12/HS Grad <input type="checkbox"/> GED <input type="checkbox"/> Technical Training <input type="checkbox"/> AA <input type="checkbox"/> BA or Higher	Education Level (check highest completed) <input type="checkbox"/> Grade 8 or less <input type="checkbox"/> Grade 9 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade12/HS Grad <input type="checkbox"/> GED <input type="checkbox"/> Technical Training <input type="checkbox"/> AA <input type="checkbox"/> BA or Higher
	Are you currently working? <input type="checkbox"/> No <input type="checkbox"/> Yes Full Time (35 hours or more /week) Part time (Less than 35 hours/week) Name of Employer _____ Income per mo _____ Yr _____ Number of people supported by this income _____ Do you or anyone in your family receive: SSI No Yes ID# _____ TANF No Yes ID# _____ WIC No Yes ID# _____	Are you currently working? <input type="checkbox"/> No <input type="checkbox"/> Yes Full Time (35 hours or more /week) Part time (Less than 35 hours/week) Name of Employer _____ Income per mo _____ Yr _____ Number of people supported by this income _____ Do you or anyone in your family receive: SSI No Yes ID# _____ TANF No Yes ID# _____ WIC No Yes ID# _____

To the best of my knowledge, the information on these forms is factual and true. Participation in Early Head Start is determined by mandated eligibility requirements, including income. Once a child has been determined Early Head Start eligible, should any information provided by the parent/guardian and used to determine that eligibility be found to be inaccurate or fraudulent, DLEC will immediately terminate Early Head Start services.

I understand that the information I have provided on this application is confidential and will not be shared without my permission. I give Early Head Start staff my permission to contact DSHS to verify my benefits if needed.

Parent/Guardian Signature

Date