Edmonds Community College Head Start & Early Head Start
Washington State Department of Early Learning

14 E Casino Rd, Bldg B
Everett, WA 98208
Phone: 425-712-9000
Fax: 425-290-3693
www.edcc.edu/birthtofive

Which program are you applying for? *(Please complete an application for each person you would like to enroll)*	❑ Head Start/ECEAP Preschool for ages 3-5	❑ Early Head Start Home-based for pregnant or ages 0-3 *If pregnant, Due Date:

Section A *- Pregnant applicants – skip to Section B and complete the rest of the application*

Child Name _____ Date of Birth _____ ☐ Female ☐ Male
First Name Last Name

Address _____
Street address Apt # City Zip

Language(s) child speaks at home: _____

Child's Race/Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Hispanic ☐ Hawaiian/Pacific Islander ☐ Multi-racial ☐ Other ☐ White

Does this child have any of the following health concerns? *(Additional information and/or forms may be needed before starting)*
Food allergy ☐ No ☐ Yes Asthma ☐ No ☐ Yes Medication ☐ No ☐ Yes

Is this child currently enrolled in our Early Head Start program? ☐ No ☐ Yes

Does this child have an IEP/IFSP? ☐ No ☐ Yes Is this child a foster child? ☐ No ☐ Yes
(special services/special education with school district or early intervention services)

Section B

Is your family currently experiencing homelessness? ☐ No ☐ Yes
(includes temporarily living in a shelter, motel, hotel, or w/family or friends)

Does family have an open CPS case? ☐ No ☐ Yes

Who we can call if we can't reach you? Name _____ Phone _____

How did you hear about our program? ☐ Family/friends ☐ Healthcare provider ☐ Online/social media
☐ WIC/Comm Action ☐ School District ☐ Community Event ☐ Received in mail ☐ Other _____

PARENT/GUARDIAN (lives w/child)	**PARENT/GUARDIAN (lives w/child ☐ No ☐ Yes)**
Name:	Name:
DOB: / / Gender: F M	DOB: / / Gender: F M
Relationship to child:	Relationship to child:
Mailing address: (if different)	Mailing address: (if different)
Email:	Email:
Primary phone: ( ) - ☐Cell OK to text: Y N ☐Home ☐Work ☐Message	Primary phone: ( ) - ☐Cell OK to text: Y N ☐Home ☐Work ☐Message
Secondary phone: ( ) - ☐Cell OK to text: Y N ☐Home ☐Work ☐Message	Secondary phone: ( ) - ☐Cell OK to text: Y N ☐Home ☐Work ☐Message
Language(s): Do you need an interpreter? ☐ No ☐ Yes	Language(s): Do you need an interpreter? ☐ No ☐ Yes

Please list all <u>additional</u> children and adults living in the household who are supported by the enrolling parents/guardians. If you need more room, please attach a separate piece of paper.		
Name	**Date of Birth**	**Relationship to Child**

Total monthly income (before taxes) $ _____ Number of people in your family: _____
(supported by monthly income)

Income sources: ❑ Wages/salary ❑ TANF ❑ Supplemental Security Income (SSI)
❑ Foster ❑ Unemployment ❑ Child support ❑ Other _____

Research Based Risk Factors *(used to determine selection criteria)*	**Yes**	**No**
Has child been expelled from an early learning program due to behavior?		
Does child live with someone other than a parent (parent does not live there)?		
Has family experienced homelessness in the past 12 months?		
Are you concerned about your child's development?		
Does child have a parent who is in jail?		
Is this a single parent household?		
Is there a history of domestic violence in the household?		
Do the parent(s) in house have a high school diploma or GED?		
Does the child have a chronic health condition (diabetes, asthma, seizures, etc)?		
Does the family have support from friends and family?		
Is there a history of substance abuse in the household?		
Is there a history of mental illness, child or adult – including maternal depression?		
Does the family have a past CPS case?		
Is a parent in the household disabled?		
Did you receive a professional referral to our program? If yes, from whom:		

Other special concerns about your child or family that you want us to know:

VERIFICATION: I verify that all family and income information I have put on this application is true and complete. I understand that false information on this form could change the status of my child's enrollment. I give permission for this information and documentation to be shared with the local Head Start program for the purpose of enrolling my child.

I understand that my family's application is not complete and cannot be processed without the following items. I have included:

[ ] Proof of my family's income for the last 12 months;

[ ] Proof of my child's date of birth *(if applying for a child)*

PARENT SIGNATURE _____ **DATE** _____

If you have any questions, call (425) 712-9000

(Rev 4/19)