Inspire Kids Early Learning Center enrollment application

Child Information – General

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth (month/day/year): _____ Gender: M F

What is this child's home language? _____ 2nd language: _____

Does this child speak: Only English Mostly English and another language Some English, but mostly another language

Only a language other than English

What is this child's race? Check all that apply:

African/African American/Black
Asian
Alaska Native/Native American/American Indian
Native Hawaiian or Pacific Islander
White
Not listed above: _____

What is your family's heritage/tribe/country of origin? _____

What is your home address?

Will you be walking with your child to the program? _____

✱ **Due to limited parking spaces, we are restricted on the number of children we can accept into the program who are not walking to the school.**

Is this child a **sibling** of a currently enrolled child at this site? Yes No If yes, what is the name of the enrolled child?

Is this child in kinship care **without** a grant amount? Yes No

Was this child adopted after foster care or kinship care or from an orphanage from another country? Yes No

Was this child recently reunited with their parent(s) after foster care or kinship care? Yes No

Does your family currently receive services through Child Protective Services (CPS), Family Assessment Response (FAR), Working childcare connection (WCCC) Yes No

Has your family received services from CPS/FAR/ICW or law enforcement/court system in the past? Yes No

Is your family currently approved for working connection childcare?

Yes – How many approved hours per week? _____

No

Has this child ever been asked to leave an early learning program because of behavior issues? Yes No

Language: English

Child Information – Health

Does this child have medical insurance? ☐ Yes ☐ No
If yes, what type? ☐ Washington Apple Health/Provider One ☐ Private Insurance ☐ Tribal ☐ Military Medical Coverage

Does this child have a regular doctor or medical clinic?

☐ Yes - Name of clinic/provider:_____ Name of medical professional: _____

☐ No

Did this child have a well-child exam within the last 12 months?

☐ Yes – Date of last exam (month/day/year): _____

☐ No ☐ Date Unknown

Does this child have dental insurance? ☐ Yes ☐ No
If yes, what type? ☐ Washington Apple Health/ProviderOne ☐ Private Insurance ☐ Tribal ☐ ABCD ☐ Military Dental Coverage

Does this child have a regular dentist or dental clinic?

☐ Yes - Name of clinic/provider: _____ Name of dental professional: _____

☐ No

Did this child have a dental exam within the last 6

☐ months? Yes – Date of last exam (month/day/year):

☐ _____ ☐ _____

No Date Unknown

☐ ☐ ☐ ☐

What is your child's immunization status? Fully immunized Exempt Not fully immunized or exempt Not sure

Has a Health Care Provider diagnosed this child with a chronic health condition (may include mental health, asthma, cancer, diabetes, seizures, ADHD, autism, spina bifida, sickle cell disease, or life-threatening allergies)? ☐ ☐ ☐

☐ Yes – Please describe: _____ The health condition is considered: Severe Moderate Mild

No

Child Information - Development

☐ ☐ ☐

Do you have concerns about this child's health? Yes – check all that apply below No

☐ Low birth weight (less than 5.5 lbs/5 lbs 8 oz.)
☐ Hearing
Vision
☐ Preterm birth less than 37 weeks
☐ Fine motor/gross motor
Food intolerance/special diet –
Please describe: _____
☐ Drug/alcohol affected
Tooth pain/decay/bleeding gums

☐ ☐

Does this child have a **current and active** Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?

☐ Yes – Please provide a copy with your application.

No – Check if any of these apply:

☐ My child has a diagnosed developmental delay or disability, has no IEP, **or** is being referred for evaluation.
My child has a suspected developmental delay or disability.

Parent/Guardian Information

This child lives with:

☐ One parent/guardian **(complete Parent/Guardian 1)**
☐ Two parents/guardians in the same household **(complete Parent/Guardian 1 & 2)**
☐ Two parents/guardians in two households **(complete Parent/Guardian 1 & 2)**

	Parent/Guardian 1	**Parent/Guardian 2**
Name	_____	_____
Relationship to child	☐ Biological/Adopted/Stepparent ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other: _____	☐ Biological/Adopted/Stepparent ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other: _____
Gender	☐ M ☐ F ☐ Not specified	☐ M ☐ F ☐ Not specified
Date of Birth (month/day/year)	_____	_____
Address (include City, State, Zip)	_____	_____
Phone	_____ ☐ Home ☐ Cell ☐ Work	_____ ☐ Home ☐ Cell ☐ Work
Alternate Phone	_____ ☐ Home ☐ Cell ☐ Work	_____ ☐ Home ☐ Cell ☐ Work
Email	_____	_____
Were you under age 18 when this child was born?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
What language(s) do you speak?	_____	_____
Do you need an interpreter for this language?	☐ Yes ☐ No	☐ Yes ☐ No
What is your race? Check all that apply	☐ African/African American/Black ☐ Asian ☐ Alaska Native/Native American/American Indian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Not listed above: _____	☐ African/African American/Black ☐ Asian ☐ Alaska Native/Native American/American Indian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Not listed above: _____
What is the **highest** level of education you completed?	☐ 6th grade or less ☐ 7th to 12th grade, no diploma or GED ☐ High school diploma ☐ GED ☐ Some college/advanced training ☐ College/professional certificate ☐ Associate degree ☐ Bachelor's degree ☐ Master's or doctorate degree ☐ None	☐ 6th grade or less ☐ 7th to 12th grade, no diploma or GED ☐ High school diploma ☐ GED ☐ Some college/advanced training ☐ College/professional certificate ☐ Associate degree ☐ Bachelor's degree ☐ Master's or doctorate degree ☐ None

	Parent/Guardian 1	Parent/Guardian 2
Are you currently employed?	☐ Yes – How many hours per week (including travel)? _____ Employer name & phone #: _____ ☐ No ☐ No, retired or disabled ☐ Seasonal	☐ Yes – How many hours per week (including travel)? _____ Employer name & phone #: _____ ☐ No ☐ No, retired or disabled ☐ Seasonal
Are you currently in job training or school?	☐ Yes – How many hours per week (including class time, study time, travel)? _____ School name & major/goal: _____ ☐ No	☐ Yes – How many hours per week (including class time, study time, travel)? _____ School name & major/goal: _____ ☐ No
Are you in an approved WorkFirst activity?	☐ Yes – Describe the activity and the number of approved hours per week: _____ ☐ No	☐ Yes – Describe the activity and the number of approved hours per week: _____ ☐ No

Family Concerns

Please check areas of concern that you have for yourself/family in your household: **(More edit required – potential for family engagement referral for the family)**

Household member has a disability **or** has a chronic physical or mental health condition **and** is:

☐ Unable to engage in work/school/family life
☐ Somewhat able to engage in work/school/ family life
☐ Mostly able to engage in Work/school/family life

☐ Child's parent/guardian has learning difficulties, no disability

☐ Household domestic violence (past or current), including *in utero*

☐ Household drug/alcohol issues or substance abuse (past or current), including *in utero*

☐ Family is socially isolated, with complete or near-complete lack of contact with others

☐ Child's parent/guardian concern for getting or keeping a job

☐ Family has legal concerns

☐ Child's parent/guardian is a migrant worker

☐ Recent immigrant/refugee (past 5 years)

☐ Child's parent/guardian is incarcerated

☐ Loss of a parent (death, abandonment, or deportation)

☐ Child's parents/guardians divorced or separated during child's life

☐ Family previously homeless (in the last 12 months)

☐ Family concerns with housing

Family Living Situation (continued)

Does this household receive subsidized housing such as a housing voucher or cash assistance for housing? Yes No

What is your family's current housing situation? **The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. Your answers may help us determine the services your child may be eligible to receive.**

Rent
Own
In a motel
In a shelter
A car, park, campsite, or similar location
Transitional Housing
Moving from place to place/couch surfing
In a residence with inadequate facilities (no water, heat, electricity)

In someone else's house or apartment with another family:
☐ By choice (e.g., to save money, to be close to family, etc.)
☐ Due to loss of housing, economic hardship, or similar reason

Other – Please describe: _____

Family Income and Family Size

Check all that apply if you, this child, or another person living in your home related to you by blood, marriage, or adoption receive these types of Public Assistance: ☐ SSI for disability received by: ☐ Child ☐ Parent/Guardian ☐ Other – Relationship to child: _______ ☐ Temporary Assistance for Needy Families (TANF) cash.
Check all that apply if your family receives the following: ☐ Child-only TANF ☐ WorkFirst ☐ Working Connections Child Care subsidy ☐ SNAP ☐ WIC
Were you referred to this program by an agency? ☐ Yes: _______ ☐ No

Please list additional people living in this child's primary household below, not including yourself or this child.				
Name (First and Last)	Birthdate (month/day/year)	Relationship to child	Do you financially support this person?	Is this person related to you by blood, marriage, or adoption?
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No
_______	_______	_______	☐ Yes ☐ No	☐ Yes ☐ No

What is the **total number** of family members living in your home, including yourself and this child? _______
What is your **total estimated** household income for the last calendar year or the last 12 months? _______

I promise that the information on this form is true and correct. I have reported all my income and family size, as required by the Early Learning Programs. If I knowingly provide false information, I understand my family may be unable to continue program services. Additionally, if my child is enrolled in ECEAP, I may have to repay the amount spent on my child.

Parent/Guardian Signature____**Date** _______________

Inspire Kids Early Learning center use only			
Section 1: Staff who finalize and determine eligibility complete this section before enrolling the child.			
Child's Age: _____	Total Verified Family Size: _____	Total Verified Income: _____	Total Points: _____
Site Name/ID: _____		Walking distance to the program ____ **(This date will determine eligibility timeframe (Please check the selection criteria scoring point)**	
Infant only - Is this child breast feeding? Yes ☐ No ☐		If yes, mother's name: _____	**Note: mother walk in to the program to breastfeed**
Section 2: For McKinney-Vento Act children/families. Check services the family received. Staff should provide resources to the family			
☐ Childcare resources ☐ Clothing resources ☐ School supplies ☐ Medical/dental referral ☐ Housing/shelter referral	☐ Immunization/medical records ☐ Vision referral ☐ Hygiene products/toiletries ☐ Food resources ☐ Birth certificate ☐	☐ Medicaid/DSHS services – Food stamps/TANF ☐ College/vocational/technical resources ☐ Alternative transportation needs Other: _____	
Staff Name & Signature: _____			**Date:** _____