EDMONDS COLLEGE
HEAD START, EARLY HEAD START, AND ECEAP

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Lynnwood WA 98036
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: ❑ N ❑ Y ❑ Home ❑ Work ❑ Message	Primary phone: ❑ Cell OK to text: ❑ N ❑ Y ❑ Home ❑ Work ❑ Message
Secondary phone: ❑ Cell OK to text: ❑ N ❑ Y ❑ Home ❑ Work ❑ Message	Secondary phone: ❑ Cell OK to text: ❑ N ❑ Y ❑ Home ❑ Work ❑ Message
Language(s): Do you need an interpreter? ❑ No ❑ Yes	Language(s): Do you need an interpreter? ❑ No ❑ Yes

Section C – Household *Please list all additional children and adults living in 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

Section D - Household Income

Total monthly income *(before taxes)* $_____

Number of people in your family _____
(supported by monthly income)

Sources of income: ❑ Wages/Salary ❑ Unemployment ❑ TANF ❑ Supplemental Security (SSI)
❑ Child Support ❑ Foster ❑ Other (Please explain): _____

Section E - Research Based Risk Factors *(used to determine selection criteria)*	**No**	**Yes**
Has the child been expelled from an early learning program due to behavior?	☐	☐
Does the child live with someone other than a parent (kinship or other guardianship)?	☐	☐
Has the family experienced homelessness in the past 12 months?	☐	☐
Are you concerned about your child's development?	☐	☐
Does the 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 the 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 or relatives?	☐	☐
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 an open or past CPS case?	☐	☐
Is a parent in 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 6/20)