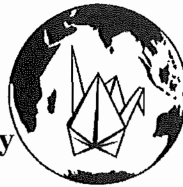
Attach a recent photo of your child



Community Day School Association

OFFICE USE:

_____ Financial Aid
_____ Parent Handbook received
_____ Signatures complete
_____ Form Complete

Date of Admission:

2011-2012 Enrollment Application

Please check one: _______School-age ________Preschool

BEFORE/AFTER SCHOOL PROGRAM NAME *(Use Black or Blue ink to fill out form)*	CHILD'S AGE	DATE OF BIRTH	GRADE
CHILD'S NAME	SEX	Ethnicity	HOME PHONE NO.

CHILD'S ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN'S NAME	DATE OF BIRTH	HOME PHONE	CELL PHONE

HOME ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS	PLACE OF EMPLOYMENT	WORK PHONE NO.

PARENT/GUARDIAN'S NAME	DATE OF BIRTH	HOME PHONE	CELL PHONE

HOME ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS	PLACE OF EMPLOYMENT	WORK PHONE NO.

EMERGENCY CONTACT IF PARENTS CANNOT BE REACHED(Authorized for pick up)	RELATIONSHIP	PHONE NO.
EMERGENCY CONTACT IF PARENT CANNOT BE REACHED(Authorized for pick-up)	RELATIONSHIP	PHONE NO.
OUT OF AREA CONTACT	RELATIONSHIP	PHONE NO.

I AUTHORIZE CDSA TO RELEASE MY CHILD TO THE ADDITIONAL FOLLOWING PEOPLE:

NAME	**RELATIONSHIP**	**PHONE NO.**
NAME	**RELATIONSHIP**	**PHONE NO.**
NAME	**RELATIONSHIP**	**PHONE NO.**

Parent's Acknowledgements: This is to acknowledge that the CDSA has provided me with my own **CDSA Family Information Guide**. I agree to read and adhere to the information included.

Parent Signature: ______________________________ Date:

Child's Description

Hair Color:____________Eye Color:____________Height:__________
Weight:__________ Ethnicity:______________________________

Distinct Features (scars, birthmarks, etc):______________________
____

CUSTODY/ COURT ORDERS

Are there any court orders affecting custody of this child? _____ Yes _____ No *(If yes you MUST provide the CDSA with a copy of these orders)*

Are there any restraining orders? _____ Yes _____ No Who has Primary custody of this child? ____________________________

Child may be released to: ( ) FATHER ( ) MOTHER ( ) OTHER/NOTES: ______________________________

Parent's Consent

TRANSPORTATION: (required for participation) I hereby give consent for my child to be transported by public transportation and supervised by the CDSA staff an[illegible] volunteers to and from field trips.

[illegible]ER ACTIVITIES: (required for participation) I hereby give my consent for my child to participate in water activities that might be offered by the CDSA. I h[illegible]by give the CDSA staff permission to assist my child in the application of sunscreen.

Parent Signature: ______________________________ Date: ______________

CDSA Mission: CDSA is dedicated to providing affordable quality childcare in safe and caring surroundings. Our goal is to promote each child's intellectual, physical and social development within a diverse community with emphasis on respect for self, others and the environment.

Health History

Please list any **DIETARY** or **PHYSICAL** restrictions:

Please list any known **ALLERGIES:**

Treatment to be given when in contact with stated **ALLERGIES:**

Please CHECK all the following that apply to your child's **HEALTH HISTORY:**

______ **ADD** ______ **ADHD** ______ **EXISTING ILLNESS**

______ **DIABETES** ______ **TAKES DAILY MEDICATION**

_______ **ASTHMA** ______ **OTHER: Please explain:** ______________

Healthy Learning Enviornment:
To ensure your child has the best tailored academic support needed, please answer the following:
Has your child ever been suspended from school? _____No _____Yes
Date: _____________ If yes, please explain_____________________
Is, or has your child ever been on an Individual Education Plan? (IEP)
_____No _____Yes If yes, please explain (include specific dates of initial IEP/ and or reviews__________________________

CDSA generally have staffing ratios in school-age of 1:10 and 1:8 in pre-school. Do you feel this will be adequate for your child's needs?
Yes ______ No ________ If No please explain ___________________

Parent's Signature: ___________________________ Date: ________

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the CDSA Director or person in charge to take my child to:

NAME OF LICENSED PHYSICIAN: ___________________________

ADDRESS: ____

PHONE NUMBER: ______________________________________

NAME OF HOSPITAL OR CLINIC: __________________________

ADDRESS: ____

PHONE NUMBER: ______________________________________

I hereby give permission for my child to be given emergency treatment by a qualified staff member at Community Day School Association, to be transported by ambulance or aid car to an emergency center, and/or to receive whatever medical, surgical, and hospital care, treatment, and procedures are deemed immediately necessary by the attending physician to safeguard my child's health.

Parent Signature: ___________________________ Date: __________

Date of last Health Exam:__________________
Date of last Dental Exam:__________________
Date of last Tetanus shot:__________________

Name of Insurance__________________ **Policy #**__________________

Family Biographical Information

We at Community Day School Association strive to insure that your child's needs are served to the capacity of our abilities. We feel in order to achieve that goal, we ask for as much information about your child as possible to enable our staff to serve all aspects of your child's needs.

1. Does your child have a nickname that they prefer?
2. Please describe some of the activities that your child prefers and some that they dislike.
3. What are some of your child's favorite foods, and some of their least favorite?
4. When your child is upset, what kind of behaviors are they likely to exhibit?
5. At CDSA we are pleased to celebrate family diversity represented in our program population.
   Please describe your family to us. (Special family traditions, siblings, relatives in household, etc.)
6. Has there been any recent family changes
7. What types of activities would you like to see your child participating in at CDSA?
8. What expectations do have for the CDSA program

I have read and completed this document to the best of my knowledge and agree that the information provided is true and accurate.

Parent/Guardian Printed Name______________________ **Parent/Guardian Signature**______________________

Date: ______________________

CDSA Mission: CDSA is dedicated to providing affordable quality childcare in safe and caring surroundings. Our goal is to promote each child's intellectual, physical and social development within a diverse community with emphasis on respect for self, others and the environment.

Community Day School Association
2011-2012 Preschool Parent Agreement

Parent's Name ____

Child's Name ______________________ Center ______________________

Please initial each agreement and sign at the bottom.

Initial

________ 1. I grant permission for CDSA to provide care to my child including use of play equipment and supplies, involvement in all activities and participation in fieldtrips.

________ 2. I have provided CDSA with the following information on the emergency form:

- ________ **Parent/Guardian name, address, home, cell and work phone numbers**
- ________ **Emergency contacts**
- ________ **Physician name and phone number**
- ________ **Food or drug allergies, asthma, disabilities, any chronic medical need, etc.**
- ________ **Persons authorized to pick up your child from CDSA plus phone numbers**
- ________ **Any additional relevant information**

________ 3. I understand that CDSA is not responsible for personal items brought from home that may be lost.

________ 4. I give permission for my child to be included in photographs taken at CDSA. I understand that photographs of my child may be used in our publications, including our website and marketing materials. I am able to withdraw my permission at any time for my child's photograph to be used in CDSA publications and will notify my Center Director in writing.

________ 5. I have read and understand the Family Information Guide and am aware that CDSA reserves the right to decline enrollment for any of the following reasons:

a. CDSA Conflict-Resolution Policy
b. Non-payment of tuition/co-payment by due date
c. Non-payment of tuition because subsidy has been denied or expired
d. Physical or emotional problems that are beyond reasonable accommodations
e. Parent/Guardian failure to comply with CDSA's policies and procedures

________ 6. I have included on the emergency form all information that could significantly affect my child's ability to work with staff & other children. I will notify CDSA of any address & phone number changes.

________ 7. CDSA is not responsible for anything that may happen as a result of incomplete information given by a parent/guardian on the emergency form or other documentation at the time of enrollment.

________ 8. Children with the mental & physical capacity to apply sun screen will self apply under the supervision of CDSA staff. If the child is unable to do so, a CDSA staff member will apply as needed.

________ 9. I agree to send a nutritionally balanced lunch with my child (ren) daily.
CDSA is required by law to monitor the nutritional content of food that is consumed during meals and snacks while in our care.

________ 10. I understand that I have access to view the center's Disaster Plan, Pesticide and Health Care Policy.

________ 11. I give permission for my child to participate in walking field trips in the neighborhood. I understand that this will occur without written permission.

More on Back.......

_______ 12. I give my permission to have my child participate in one health screening and three developmental screenings during the school year and also give permission to disclose information regarding my child's health to Public Health and the City of Seattle if further evaluations and screenings are needed. I also understand that if my child is identified to have learning difficulties that an intervention plan will be developed and implemented in partnership between myself, the teachers, Public Health and the City of Seattle.

_______ 13. In understanding the importance of the learning that happens when children attend preschool consistently, I commit to ensuring that my child attends preschool 85% of the time during the school year (this does not include excused absences: illness, family emergency, religious observances or practices, and culturally relevant family activities).

_______ 14. I have read and understand the Child of Concern Policy

_______ 15. I have reviewed the summary of the Disaster Plan in the Family Information Guide and know where a copy of the full plan is located.

Signature: ______________________________ Date: ____________________

How did you hear about CDSA?

_____ Flier mailed to my home
_____ Flier came home with my child, from Seattle Public Schools
_____ Roadside Banner or Lawn Sign
_____ Internet/Web Site
_____ CDSA Employee ______________________________
_____ CDSA Parent ______________________________
_____ Other ______________________________

Community Day School Association
2011-2012 Preschool Tuition Agreement

Parent's Name ______________________________

Child's Name ______________________ Center ______________________

Please initial each agreement and sign at the bottom.
Return original to the Center Director and keep one copy for your files.

Initial

________ 1. An annual registration fee of $50 per child is payable at the time of registration and is non-refundable.

________ Paid ________ Included

________ 2. My base tuition is $____________ per month, payable **IN ADVANCE.** 10% sibling discount applies to base tuition only. **Preschool tuition** is based on a 12-month year and **100% tuition will be charged year round**.

________ 3. ***(For subsidized families)*** My copayment amount is determined by the funding organization and is subject to change. I understand that I am responsible for payment of care not covered by the funding source and my copayment for care is payable in advance. My funding organization is (circle one) DSHS City of Seattle

________ 4. ***(For subsidized families)*** **Written proof of coverage is required before care can begin. If proof cannot be obtained prior to enrollment, you must pay in advance for your child's care.** You must be allocated full-time hours from your subsidy organization to get full time care during school breaks, in-service days, and other school closures. If you are only allocated half-time care, your child may only attend for half a day. **For city subsidy families**, additional fees will be charged for full day care during school breaks, in-service days, and other school closures.

________ 5. ***(For subsidized families)*** **DSHS** - Absences may not exceed five (5) per month. **City** – Absences may not exceed ten (10) per month. Children with excessive absences may be asked to leave the program.

________ 6. My child will attend CDSA: 5 days ONLY

7 a.m.-3 p.m.	MON	TUE	WED	THU	FRI
7 a.m.-6 p.m.	MON	TUE	WED	THU	FRI
9 a.m-3 p.m.	MON	TUE	WED	THU	FRI
9 a.m.-6 p.m.	MON	TUE	WED	THU	FRI

________ 7. CDSA provides optional care on in-service days, early dismissal, and other school closure days. Optional care is not part of your regular schedule and is provided at an additional fee to be paid in advance of the care. Drop in care is also available at an additional fee.

________ 8. Refunds are not given for sick days, snow days, natural disasters or other unscheduled absences.

________ 9. I agree that should I need to make a schedule change or cancel childcare needs that I submit a **Schedule Change Form no later than the 20th of the month preceding the change** and I agree that tuition will not be refunded within the month following the date notification of a change was made.

________ 10. Child(ren) must be picked up by 6 p.m. Beginning at 6:01 p.m., a $5.00 late charge will be assessed for the first five minutes and then $1.00 for every minute thereafter payable to CDSA the same day.

________ 11. **(Optional)** I agree to receive my monthly tuition invoice via email

Signature______________________________ Date ________________

Rev. 08/10

Washington State Department of Health

Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ☐ Yes ☐ No

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy): **Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

Vaccine	Dose	Date: Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date: Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission

Printed Staff Name	Date	Printed Staff Name	Date
Printed Staff Name	Date	Printed Staff Name	Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) ☐ Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) ☐ Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ☐ Signed note from HCP attached **OR**
2B) ☐ HCP signed here and print name below:

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: ____________

3) ☐ Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: ________(initial) ________(date)

4) ☐ Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
Age/Date of disease: ____________
*Can **ONLY** verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) MUST also be attached.**

- ☐ Diphtheria
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hib
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Rubella
- ☐ Tetanus
- ☐ Varicella
- ☐ Other: ____________

Licensed health care provider (HCP) Signature Date
(MD, DO, ND, PA, ARNP)
HCP Printed Name:

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand:

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

EXAMPLE

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
2) ❑ If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
3) ❑ If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
4) ❑ If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports.**

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrcl)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

Community Day School Association
Celebrating Quality Childcare Since 1977

Community Day School Association (CDSA)
5333 15th Ave S, Suite 1L
Seattle, WA 98108
206-726-7972
communitydayschool.org

"Discovering and Cultivating the Best in Each Child"

Dear CDSA Family,

As a part of the **Child and Adult Care Food Program (CACFP)**, CDSA is able to be reimbursed for a portion of the meal costs for all children in our programs. **This program allows us to provide quality snacks for your children while at the same time helping us to be able to keep other things like tuition costs low for our families.** Please help to continue participating in this program by completing the attached Enrollment/Income Eligibility Application (E/IEA), regardless of income, when you enroll your child. If you have any questions about the application, please speak directly with your Center Director, call the administration office or refer to pages 12 &13 in the Family Information Guide.

Sincerely,

Brianna Jackson
Director of Operations
Community Day School Association

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 - CHILDREN'S INFORMATION—Required for all children in care

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 - FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children

PART 4 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2

List Names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month (if None, Write "0") (or net income if self-employed)			
	Earnings from Work Before Deductions	Alimony, Child Support, Welfare	Retirement, Pensions, Social Security	Job Two or Any Other Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PART 5 - SIGNATURE AND CERTIFICATION - REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing Social Security Number (last four digits) XXX-XX-	☐ I do not have a Social Security Number
dress	City/State/Zip Code	Daytime Phone	

Attachment 1 to Bulletin No. 013-11 CNS
May 2, 2011

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, gender, age, or disability.

Race:
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

If you feel you have been discriminated against, you should write USDA, Director of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410.

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires that, unless a household member's Basic Food, TANF, or FDPIR case number is provided or you are applying on behalf of a foster child, you must include the last four digits of the Social Security Number of the adult household member signing the application, or indicate that the household member does not have a Social Security Number. Provision of the last four digits of the Social Security Number is not mandatory, but if the last four digits of the Social Security Number is not provided or an indication is not made that the signer does not have a Social Security Number, the application cannot be approved in the free or reduced-price category. This notice must be brought to the attention of the household member whose last four digits of the Social Security Number is disclosed. The last four digits of the Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Basic Food or welfare office to determine current certification for receipt of Basic Food or TANF benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY

Check one:
- ☐ Free Category
- ☐ Reduced-Price Category
- ☐ Above-Scale Category

Total Monthly Income $____________________

This form must be signed and dated by the institution's representative.

______________________________________ ____________________

Signature of Institution's Representative Date

Standardized Client Demographic Data Collection Form
For use in School Year 2011-2012

Agency	Community Day School Association (CDSA)	0000012243

Client Instructions: *Please neatly enter numbers or make an **X** in the appropriate boxes to answer the questions. Please note your name is not a part of this survey so that your identity is totally confidential.*

I. Geographic Region:

1. What is the Zip Code where you live:
☐☐☐☐☐
Homeless – formerly from ZIP and/or City

2. City Name ______________________________
(if not in a city, write in "Unincorporated")

☐ Unknown

II. Household Composition

1. Number of people living in your household (including yourself) ☐☐

☐ Unknown

2. Number of children under 18 ☐☐
☐ Unknown

3. If you are in a single parent household, is the head of the household male or female?

☐ Male (1)
☐ Female (2)
☐ Unknown (9)

III. Household Income Level

1. What is the total gross yearly income for your household, based on King County HUD guidelines? (See Attachment)

☐ Under 30% of Median Income (1)
☐ Under 50% of Median Income (2)
☐ Under 80% of Median Income (3)
☐ Equal or Above 80% of Median Income (4)
☐ Unknown (9)

IV. Living Situation

1. Are you Homeless?
☐ Yes (1)
☐ No (0)
☐ Unknown (9)

If homeless **"Yes"**,

2. How many times have you been homeless in the past three years?

Number of times ☐☐ Unknown ☐

3. How long have you been homeless this last time?

Number of months ☐☐ Unknown ☐

V. Age Group

1. What is your child's age at intake?

Number of Years ☐☐☐
☐ Age Unknown

VI. Gender

1. Please check one of the following

☐ Female (1)
☐ Male (2)
☐ Transgendered (3)
☐ Other (4)
☐ Unknown (9)

VII. Persons with Disabilities

1. Do you consider yourself to be a person with a disability?
☐ Yes (1)
☐ No (0)
☐ Unknown (9)

VIII. Hispanic/Spanish/Latino

1. Are you Spanish/Hispanic/Latino?
☐ Yes (1)
☐ No (0)
☐ Unknown (9)

(Continued on Page 2)

IX. Race

1. What is your race? **(Check all that apply)**

a.
- ☐ American Indian (U.S. Tribe)
- ☐ Alaska Native, Aleut, Eskimo
- ☐ Indigenous to Americas (Other than U.S.)

b.
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese, Except Taiwanese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

c.
- ☐ Indigenous African/Black
- ☐ African American/Black
- ☐ Other Black

d.
- ☐ Hawaiian Native
- ☐ Polynesian (Samoan, Tongan, Other)
- ☐ Micronesian (Guamanian/Chamorro, Other)
- ☐ Other Pacific Islander

e.
- ☐ Arab/Iranian or Middle Eastern
- ☐ Other White/Caucasian

f.
- ☐ Other

G.
- ☐ Unknown

X. Refugee/Immigrant

1. Are you an immigrant or refugee or new arrival to this country?
- ☐ Yes (1)
- ☐ No (0)
- ☐ Unknown (9)

XI. Limited English Proficiency

1. Are you limited in your ability to communicate in English?
- ☐ Yes (1)
- ☐ No (0)
- ☐ Unknown (9)

XII. Employment Status at Intake

1. Are you currently employed?
- ☐ Yes (1)
- ☐ No (0)
- ☐ Unknown (9)

XIII. Educational Level Adults (for adults only)

1. What is the highest grade or degree that you have achieved?

- ☐ Less than High School graduate (1)
- ☐ High School diploma or GED (2)
- ☐ Some college–no degree or certificate (3)
- ☐ Certificate from business school or other professional program (4)
- ☐ Associates Degree (5)
- ☐ Bachelors Degree or above (6)
- ☐ Child under 18 (7)
- ☐ Unknown (9)

XIV. Veterans/Military Status

1. Have you ever served on active duty in the U.S. military (including National Guard or Reserves)
- ☐ Yes (1)
- ☐ No (0)
- ☐ Unknown (9)

XV. Program

1. In what program is your child enrolled?
- ☐ Pre-K (1)
- ☐ School Age (2)
- ☐ Unknown (9)

XVI. Language

1. Other than English, please list other languages spoken in your home.

____

____

Thank you for your cooperation. Individual responses will be kept completely confidential at all times

United Way of King County

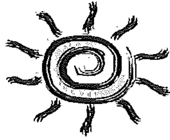
2010 - 2011 HUD Income Categories

Instructions: Find the column for the number of people in your household. Go down that column until you find the income range for your annual gross income last year. Look to the left to see what that row is labeled. That is your income category.

Household → ↓ Category	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
Category A. Very Low. 30% HUD PMSA	Up to $18,250	Up to $20,850	Up to $23,450	Up to $26,050	Up to $28,150	Up to $30,250	Up to $32,350	Up to $34,400
Category B. Low. 50% HUD PMSA	$18,251 to $30,400	$20,851 to $34,750	$23,451 to $39,100	$26,051 to $43,400	$28,151 to $46,900	$30,251 to $50,350	$32,351 to $53,850	$34,401 to $57,300
Category C. Moderate. 80% HUD PMSA	$30,401 to $44,950	$34,751 to $51,400	$39,101 to $57,800	$43,401 to $64,200	$46,901 to $69,350	$50,351 to $74,500	$53,851 to $79,650	$57,301 to $84,750
Category D. Above Moderate. Above 80% HUD PMSA	$44,951 or More	$51,401 or More	$57,801 or More	$64,201 or More	$69,351 or More	$74,501 or More	$79,651 or More	$84,751 or More

Note:
- **FY 2011, Washington State Median 4-Person Family Income = $81,684**
- **HUD (U.S. Department of Housing & Urban Development)**
- **PMSA (Primary Metropolitan Statistical Areas)**

Public Health
Seattle & King County



Sunscreen Authorization Form

(Program-Provided/Bulk Sunscreen)

Child's Name:	Date of Birth & Age: (Do not apply on infants 6 months & younger without written permission from health care provider)
Start Date:	Stop Date: (up to 6 months after 'start date')
Times to be Applied:	Special Instructions:

I authorize the use of the following "program-provided" sunscreen on my child.

________________________________ _____________________
Parent/Guardian Signature Date

____
Daytime Phone Number

Program-Provided Sunscreen *(to be completed by child care provider)*

Name of Sunscreen & SPF:	Active Ingredients:
Possible Side Effects:	Other Label Information:

Reason for medication: Protection from sun
Amount to be given: Cover exposed areas of skin
Route: Topical
Storage: Room temperature

Agency:______________________ Site Name:______________________
Assigned Classroom:______________________ Teacher:______________________
☐ A.M. ☐ P.M. ☐ Full Day

Seattle Step Ahead Preschools

STEP AHEAD CHILD ENROLLMENT FORM School Year 2011-2012 ☐**Step Ahead** ☐**Head Start** ☐**Match**

CHILD INFORMATION

1. Last Name: ____________ First: ____________ Middle: ____________
2. Child's Birth Date ____/____/______ 3. Sex: ☐ F ☐ M
4. Living Address: ____________ City: ____________ State: ______ Zip: ______
5. Mailing Address: ____________ City: ____________ State: ______ Zip: ______
6. County: ____________ 7. School District ***(if known)***: ____________
8. Daytime Phone: (____)____________ Evening Phone: (____)____________ Message Phone: (____)____________

9. Is child of Spanish/Hispanic/Latino ethnicity ***(optional)***: ☐ Yes ☐ No ***This question is about ethnicity, not race.***
10. Race *(optional)* ☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian or Alaska Native ☐ Black, African, or African American
11. Languages Spoken in Home:
Primary: ____________ Secondary: ____________

Are you a refugee or immigrant family? ☐Yes ☐ No

12. Child has Individual Education Plan (IEP): ☐ ***If checked, school district***: ____________
13. Family Receives DSHS Child Care Subsidies (Working Connections Child Care) for this Child: ☐ Yes ☐ No
14. Child is homeless according to the McKinney-Vento Act: ☐ Yes ☐ No ***(See page 7 for more information.)***
15. Child resides with: ☐ Single Parent* (in joint custody cases, use parent that receives child support)
☐ Two Parents*
☐ Other: ____________ ***(please specify)***

** Parent means birth parent, custodial parent, foster parent, legal guardian, or other person <u>legally</u> responsible for the welfare of the child.*

Additional Questions For All Parents (questions not on downloadable translated enrollment forms)

Child has:

☐ Attended preschool ☐ **Head Start** ☐ **ECEAP** ☐ **Other** preschool program Total number of months: ______

Did child attend **<u>Head Start</u>** as a three year old? ☐ Yes ☐ No ☐ Full Day ☐ Part Day
How many months? ______

Did child attend **<u>ECEAP</u>** as a three year old? ☐ Yes ☐ No ☐ Full Day ☐ Part Day
How many months? ______

Did child attend **<u>other Preschool</u>** as a three year old? ☐ Yes ☐ No ☐ Full Day ☐ Part Day
How many months? ______

☐ Received care at a child care home:
☐ Licensed ☐ Full time ☐ Part time Total number of months: ______

☐ Been cared for by friend or neighbor or family member, other than the parent:
☐ Full time ☐ Part time Total number of months: ______

Child or Family has:

☐ Received regular home visits through a program, such as Nurse Family Partnership, Promoting First Relationships or Parents as Teachers: Total number of months: ______

Child Participated in **Parent Child Home Program (PCHP)** ☐ Yes ☐ No

STEP AHEAD CHILD ENROLLMENT FORM

PARENT/CARETAKER INFORMATION

	Parent 1	***Parent 2***
	Name ______	*Name* ______
16.	(Last) (First) (MI)	(Last) (First) (MI)
17.	Gender: ☐ F ☐ M	Gender: ☐ F ☐ M
18.	***Relationship to Child:*** ☐ Parent (biological/adoptive) ☐ Parent (legal stepparent) ☐ Grandparent ☐ Foster Parent ***(If yes, skip to question #26)*** ☐ Other Caretaker ☐Relative:________________ ☐ Other Legal Guardian	***Relationship to Child:*** ☐ Parent (biological/adoptive) ☐ Parent (legal stepparent) ☐ Grandparent ☐ Foster Parent ***(If yes, skip to question #26)*** ☐ Other Caretaker ☐ Relative:________________ ☐ Other Legal Guardian
19.	***Age:*** ☐ Under 18 ☐ 18-24 ☐ 25-35 ☐ 36-45 ☐ 46-55 ☐ Over 55	***Age:*** ☐ Under 18 ☐ 18-24 ☐ 25-35 ☐ 36-45 ☐ 46-55 ☐ Over 55
20.	***Education Level:*** ☐ 6th grade or less ☐ Some college ☐ 7th–9th grade ☐ 2-year degree ☐ 10th–12th grade ☐ 4-year degree ☐ High School Diploma ☐ Vocational degree ☐ GED ☐ Other	***Education Level:*** ☐ 6th grade or less ☐ Some college ☐ 7th–9th grade ☐ 2-year degree ☐ 10th–12th grade ☐ 4-year degree ☐ High School Diploma ☐ Vocational Degree ☐ GED ☐ Other
21.	***Check any education or training currently involved in (check all that apply):*** ☐ ESL ☐ High School ☐ GED ☐ Even Start ☐ Voc/tech Program ☐ Other ____________ ☐ College ☐ None	***Check any education or training currently involved in (check all that apply):*** ☐ ESL ☐ High School ☐ GED ☐ Even Start ☐ Voc/tech Program ☐ Other ____________ ☐ College ☐ None
22.	***Employment Status*** ☐ Full-time ☐ Looking for work ☐ Part-time ☐ Not looking for work	***Employment Status*** ☐ Full-time ☐ Looking for work ☐ Part-time ☐ Not looking for work
23.	***Migrant/Seasonal Farm Worker:*** ☐ Yes ☐ No	***Migrant/Seasonal Farm Worker:*** ☐ Yes ☐ No
24.	***Parent/Caretaker is enrolled in medical/dental plan (check all that apply)*** ☐ Medicaid ☐ Medicare ☐ Washington Basic Health Plan ☐ Washington Basic Health Plan Plus ☐ Private/Employer Medical Insurance ☐ Private/Employer Dental Insurance ☐ Other: ______________________	***Parent/Caretaker is enrolled in medical/dental plan (check all that apply)*** ☐ Medicaid ☐ Medicare ☐ Washington Basic Health Plan ☐ Washington Basic Health Plan Plus ☐ Private/Employer Medical Insurance ☐ Private/Employer Dental Insurance ☐ Other: ______________________
25.	Parent/Caretaker has primary health care provider or medical home ☐ Yes ☐ No	Parent/Caretaker has primary health care provider or medical home ☐ Yes ☐ No

STEP AHEAD CHILD ENROLLMENT FORM

HOUSEHOLD INFORMATION

26. Family Size: ____________________ ***(See Page 7 for more information.)***

27. Eligibility is Based on Income
    (Check one, or go to question #28 if family is over 110% Federal Poverty Level [FPL])
    (Count income from all sources as listed on page 7.)

    ☐ Annual or previous 12 month's gross income $______________

    ☐ Current/previous month's gross income: $______________

28. Family is over 110% FPL. Annual or previous 12 month's gross income: $______________
    Federal Poverty Guidelines (FPG): _______%

29. Income Source ***(check all that apply, also see page 6 to apply for cost assistance)***:
    ☐ Wages/Salary
    ☐ Supplemental Security (SSI)
    ☐ TANF
    ☐ Child Support
    ☐ Unemployment Benefits
    ☐ Other:______________
    ☐ Pension, Retirement, and/or Social Security
    ☐ Alimony/Spousal Support

30. Family accesses the following social services ***(check all that apply)***:
    ☐ Food Stamps
    ☐ Food Banks
    ☐ WIC
    ☐ Housing Subsidies
    ☐ Energy Assistance
    ☐ Other Local Programs (***please specify***):
    ☐ Homeless Services

    ____

CHILD MEDICAL/DENTAL HEALTH INFORMATION

31. **Child is enrolled in the following *medical insurance and/or child health programs* *(check all that apply)*:**
    ☐ Medicaid
    ☐ Children's Health Insurance Program (CHIP)
    ☐ Private Medical Insurance
    ☐ Washington Basic Health Plan
    ☐ Washington Basic Health Plan Plus
    ☐ No Medical Insurance
    ☐ Other

32. **Child is enrolled in the following *dental insurance and/or dental health programs* *(check all that apply)*:**
    ☐ Medicaid, Washington Basic Health Plan Plus, or Children's Health Insurance Program (CHIP)
    (These health programs include dental coverage.)
    ☐ Private Medical Insurance
    ☐ No Medical Insurance
    ☐ Other

33. **Child has primary health care provider or medical home:**
    ☐ Yes ☐ No

34. Date of last medical exam ***(prior to first service date)***: _____/_____/_____
    If date of last medical exam was completed over one year ago or left blank, provide date medical exam completed while in Step Ahead ***(must be completed within 90 days of the first service date)***: _____/_____/_____

35. Date of last dental exam ***(prior to first service date)***: _____/_____/_____
    If date of last dental exam was completed over six months ago or left blank, provide date dental exam completed while in Step Ahead ***(must be completed within 90 days of the first service date)***: _____/_____/_____

36. Child is fully immunized with age appropriate vaccines (per DOH Immunization Schedule): ☐ Yes ☐ No ***RCW 28A.210.160 requires a completed Certificate of Immunization Status on file at the school, preschool, or child care facility child attends (except in cases of homelessness).***
    a) If child is not fully immunized at time of enrollment, an immunization schedule is in progress: ☐ Yes ☐ No
    b) If child is not immunized, a DOH required Statement of Exemption to Immunization Law is signed and on file: ☐ Yes ☐ No
    c) Date child became fully immunized while in Step Ahead: _____/_____/_____

STEP AHEAD CHILD ENROLLMENT FORM

SEEC/Step Ahead is funded by the Seattle Families & Education Levy. I understand that some or all of the above information must be reported to the funding agencies and to other City departments and state agencies. The information may also be shared with Seattle Public Schools and other non-governmental research firms under contract with either funder.

I certify that the information I have provided on this form is correct.

I hereby authorize Seattle Public Schools to release to the City of Seattle as administrator of both SEEC/Step Ahead and City of Seattle ECEAP my child's student identification number. I understand that the City intends to use some or all information gathered during the course of the program solely for the purposes of assessing program effectiveness, both short- and long-term as the child progresses through Seattle Public Schools. I further understand that the identification of my child and family will be kept confidential to the extent required or authorized by local, state, and federal law.

________________________________	________________________
Child's Name	Relationship to Child
Signature of Parent or Caretaker	Date
Signature of Person who Verified Eligibility	Date

Established Eligibility

For Agency Staff Use Only

Enrollment Information:

37. Enrollment date: ____/____/____ ***(Date when enrollment process is confirmed and slot is reserved.)***

38. Did child receive ECEAP services in the previous year: ☐ Yes ☐ No

39. Has child received Step Ahead services from another contractor this program year:
☐Yes ☐No If yes, what city? ____________

40. Child will be transported by Step Ahead ☐ One way ☐ Both ways
☐ Not transported by Step Ahead

41. Site code: ________________ First service date: ____/____/____
Exit date: ____/____/____

Reason:____

Transfers/Returns: ***(To be used when child transfers from another Step Ahead site, or exits the program and returns during the same program year.)***

42. ☐Transfer/☐Return Site code: ____________Service date: ____/____/____
Exit date: ____/____/____

43. ☐Transfer/☐Return Site code: ____________Service date: ____/____/____
Exit date: ____/____/____

Comments to CSU: ____

Form type: ☐New enrollment ☐ Update medical-dental ☐ Update transfer or return
☐ Notify that child exited

Additional Questions For All Parents (questions not on downloadable translated enrollment forms)

How did you hear about our programs?

☐ Newspaper	☐ Magazine	☐ Radio Ad	☐ Friend or Family Member
☐ Flyers	☐ Brochures	☐ Banners	☐ I Have Another Child in the Program
☐ Website	☐ Provider Recruitment	☐ Other ____________	

City of Seattle
Step Ahead
Seattle Early Education Collaborative (SEEC)
PARENT/GUARDIAN CONSENT FORM

Each service/activity is designed to enhance your child's participation in the program.
I give permission for ______________________________________to participate in the following services/activities, initialed by me, while he/she is involved in Step Ahead or Seattle Early Education Collaborative (SEEC).

Parent/Guardian Initials	Item
	To receive a developmental skills assessment, e.g., Devereux Early Childhood Assessment (DECA), Early Screening Inventory (ESI), speech/language fine and gross motor screening, behavioral screening, Ages/Stages.
	To be transported on program field trips about which I have been notified.
	To be photographed or video-taped for educational purposes and advertising Step Ahead/SEEC through various mediums e.g. internet, flyers, brochures.
	To transport my child to and from the program, (*if such services are available*).
	To receive dental screenings, (*if such services are available*).
	To receive weight and height screenings.
	To receive hearing screenings.
	To receive vision screenings.

I have read or have had this consent form explained/translated for me and understand it, and consent to my child participating/receiving those activities/services which are initialed above.
I understand that I have rights of access to all of the above records.

______________________________ ____________
Parent/Guardian Signature Date

______________________________ ____________ ______________________
Staff Signature Date Program Name

STEP AHEAD CHILD ENROLLMENT FORM

City of Seattle Subsidy Addendum

Information on this page is only needed if applying for City of Seattle cost assistance for full day program.

Eligibility includes: Family's income is between 175% - 300% Federal Poverty Guidelines, and
Family is not eligible for other subsidy programs, and
Family lives in City of Seattle

Parent/Caretaker 1	Parent/Caretaker 2
Parent/Caretaker Name: ______________________	Parent/Caretaker Name: ______________________
Date of Birth: ______________	Date of Birth: ______________
Ethnicity____________ Language____________	Ethnicity____________ Language____________
E-mail Address: ______________________	E-mail Address: ______________________
Employer Name: ______________________	Employer Name: ______________________
Employer Address: ______________________	Employer Address: ______________________
Work Phone: ______________________	Work Phone: ______________________
Job Title: ______________ Start Date:__________	Job Title: ______________ Start Date:__________
Is Parent/Caretaker Attending School? Yes ☐No ☐	Is Parent/Caretaker Attending School? Yes ☐No ☐
Training Program Title: ______________________	Training Program Title: ______________________
School Name: ______________________	School Name: ______________________

Income Check all that apply & enter monthly amount before deductions.		**Income** Check all that apply & enter monthly amount before deductions	
☐ Wages/Salary (including self-employed income)	$__________	☐ Wages/Salary (including self-employed income)	$__________
☐ Child Support, Alimony Received	$__________	☐ Child Support, Alimony Received	$__________
☐ Pension, Retirement, Social Security	$__________	☐ Pension, Retirement, Social Security	$__________
☐ Supplemental Security (SSI)	$__________	☐ Supplemental Security (SSI)	$__________
☐ Unemployment Benefits	$__________	☐ Unemployment Benefits	$__________
☐ Alimony/Spousal Support	$__________	☐ Alimony/Spousal Support	$__________
☐ TANF	$__________	☐ TANF	$__________
☐ Other (explain)	$__________	☐ Other (explain)	$__________
☐ Financial Aid	$__________	☐ Financial Aid	$__________
☐ Child Support **PAID** Out	(-$__________)	☐ Child Support **PAID O**ut	(-$__________)
Total Monthly Income	**$**__________	**Total Monthly Income**	**$**__________

Please list all family members who reside in the home:

Name	Relationship	Gender	DOB	Ethnicity	Language

Documentation of income is required. Employed Parent/Caretaker: Include wage stubs to cover latest month of employment. Three months of wage stubs are required if income varies. Self-employed parent/caretaker must fill out 6 month income and expense form, and provide receipts for one month. For child support, a six month payment history is required.

Student Parent/Caretaker: Attach class schedule, an official copy of registration, and financial aid award letter (if applicable). Income documentation is also required.

Additional Information to Complete Enrollment Form

Child Information (See question 14)
Children from homeless families as defined by the federal McKinney-Vento Homeless Assistance Act. This includes children who:

- Lack a fixed, regular, and adequate nighttime residence.
- Share housing of other persons due to loss of housing, economic hardship, or a similar reason.
- Live in motels, hotels, temporary trailers, or campgrounds.
- Live in emergency or transitional shelters.
- Are abandoned in hospitals.
- Are awaiting foster care placement.

Household Information (See question 26)
Family Size:

- Count all persons living in the household with the Step Ahead child who share finances and are related to the child's parent by blood, marriage, adoption, or other legal obligation to provide support for the child.
- For homeless families temporarily sharing housing with relatives, do not include the hosts in the total family size.
- For foster children, count only the children covered by the foster care grant in the family size.

Family Income: (See question 27)

Count the following income:

- Gross wages or salaries, and net income from self-employment, of all adults counted in the family size.
- Cash benefits to adults or children counted in the family size, such as TANF, Social Security, Supplemental Security Income, Emergency Assistance, Unemployment or Workers Compensation, training stipends, veteran's benefits, alimony, child support, DSHS foster care grant, pensions, periodic insurance or annuity payments or scholarships/grants for living expenses.

Income does not include:

- Non-cash benefits, such as food stamps, housing vouchers, Medicaid, Medicare, employee fringe benefits.
- Food or housing received in lieu of wages.
- Assets drawn down, such as cash from sale of an asset or bank withdrawals.
- One-time gifts, loans, lump-sum inheritances, insurance payments, or compensations for injury.
- Scholarships/educational grants for tuition.

Eligibility may be determined based on the time period below that best reflects the family's current financial circumstances:

- Previous calendar year before enrollment, or
- Twelve months before enrollment, or
- Previous or current month, when recent income is significantly decreased due to death, divorce, unexpected job loss, or similar circumstance.

All families on Temporary Assistance to Needy Families (TANF) cash assistance and all foster children are eligible for ECEAP services.