

1. Applicant and Family Member Information

Program Year 20__ - 20__

Primary Adult						
First	Middle	Last	Nickname	Birthday	Gender	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative		<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other		
	<input type="checkbox"/> Master's					If teen parent, subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:						

Referral				
Date of Referral	Referral made by:	Contact Person	Phone Number	How did you hear about DLEC

Need Identified				
Emergency (Basic Needs) <input type="checkbox"/> Yes <input type="checkbox"/> No	Housing Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health Services <input type="checkbox"/> Yes <input type="checkbox"/> No	ESL Training <input type="checkbox"/> Yes <input type="checkbox"/> No	Adult Education <input type="checkbox"/> Yes <input type="checkbox"/> No
Job Training <input type="checkbox"/> Yes <input type="checkbox"/> No	Substance Abuse Prevention <input type="checkbox"/> Yes <input type="checkbox"/> No	Substance Abuse Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Abuse Services <input type="checkbox"/> Yes <input type="checkbox"/> No	Domestic Violence Services <input type="checkbox"/> Yes <input type="checkbox"/> No
Health Education <input type="checkbox"/> Yes <input type="checkbox"/> No	Incarcerated Individuals <input type="checkbox"/> Yes <input type="checkbox"/> No	Parenting Education <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship Education <input type="checkbox"/> Yes <input type="checkbox"/> No	Financial Education <input type="checkbox"/> Yes <input type="checkbox"/> No

Secondary Adult						
First	Middle	Last	Nickname	Birthday	Gender	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	
Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes	<input type="checkbox"/> Lives with Family
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No	<input type="checkbox"/> Provides Financial Support
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative		<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster		
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other		
	<input type="checkbox"/> Master's					If teen parent, subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:						

Prenatal (Complete if any of the caregivers are pregnant)				
Primary Health Coverage	Other Coverage		Medicaid Eligibility	Doctor/Medical Home
			<input type="checkbox"/> Not Eligible	
			<input type="checkbox"/> On Medicaid	
			<input type="checkbox"/> Potentially	
Due date	Any difficulties with pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Facility for birth?	Is this application for your pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you interested in Birth Doula Services? <input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant (Child)						
First	Middle	Last	Nickname	Birthday	Gender	
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little		<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate		<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Other: _____			<input type="checkbox"/> Proficient		<input type="checkbox"/> Proficient	
Primary Health Coverage	Other Coverage	Medicaid Eligibility	Doctor/Medical Home	Dental Coverage	Dentist/Dental Home	
		<input type="checkbox"/> Not Eligible				
		<input type="checkbox"/> On Medicaid				
		<input type="checkbox"/> Potentially				
Applicant transferred from an external EHS to DLEC-EHS		Applicant transferred from an external HS to DLEC-HS		Applicant transition from any EHS to DLEC-HS		Immigrant / Refugee (Relocated 1 year or less)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

2. Other Family Members Information

Other Family Members				
Are there other children residing in the home (other than the applicant)?	Does the child have a cousin currently enrolled in DLEC?	Does the child have a sibling enrolled in DLEC?	Other adults living in the home?	What is their financial contribution to the household?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Full Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Full Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Child Residing in the Home (Non-Applicant) *															
First	Middle	Last	Nickname	Birthday	Gender										
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Child's Relationship		Custody	Check all that apply		Email:										
<input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent If teen parent, subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No												

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Child's Relationship		Custody	Check all that apply		Email:										
<input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent If teen parent, subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No												

* If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.

3. Family Information

Family Information

Family Living Address

Started Living at Date Living Address Address Line 2 ZIP City State County

Family Mailing Address

Same as living? Started Using Date Mailing Address Address Line 2 ZIP City State

Yes No

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)

Yes No
 Shelter Living temporarily with relative Rent Own Other:
 Temporary Transitional Housing Motel/Hotel

Phone Number(s) Type (*check one*) Note (extension or best time to call) Text Messages

Cell Home Work Other Yes No

Cell Home Work Other Yes No

Cell Home Work Other Yes No

Parental Status (*check one*) Primary Language at Home Do you need an interpreter? Active Duty Military Veteran Referred by Child Welfare Agency

One Two Yes No Yes No Yes No Yes No

Receiving Food stamps (SNAP) WIC TANF (Work First) TANF (Other) Supplemental Security Income (SSI) Marital Status

Yes No Yes No Yes No Yes No No No Married Single Divorced Widowed Separated

4. Health and Education Information about Child Applicant

General Concerns

Do you have any concerns for your child? Does your child have a condition that requires accommodation? Does your child have a diagnosed disability IEP/IFSP (Special Education)

Yes No Yes No Yes No

Please check all that apply:
 Dental Health Physical Health
 Learning difficulties Speech
 Hearing Behavior Vision
 Nutrition/Eating Former/Transition Foster Child
 Abuse/Neglect
 Other:

Please check all that apply:
 Food Allergy Medicine Allergy
 Non-food Allergy Asthma
 Seizures TB Positive
 Other:

If yes, please name the service provider:
 Boyer Children's Clinic Kinderling Center
 ChildStrive Northwest Center Kids
 Wonderland Developmental Center
 Encompass Experimental Education Unit
 Birth to Three Developmental Center
 SKIP Early Intervention
 Other:

5. Notes / Comments

General Notes or Comments

6. Placement for Applicant

Program Options for Prenatal Services, Infants and Toddlers (Birth to 3 years old)

Home Based - Early Head Start Program Service Area: Call our enrollment team for more information.	Home Based - ParentChild+ Program Service Area: North Seattle	ChildCare at Mercy Magnuson Place Early Learning Center 7101 62 nd Ave NE Seattle, WA 98115
About this program: Weekly 90 minutes home visits all year long for children 0 to 3 years old and pregnant women. Is your child applying for this program? <input type="checkbox"/> Yes <input type="checkbox"/> No	About this program: Two weekly 30 minutes home visits for 23 weeks. It is available for children between 16 to 30 months. Is your child applying for this program? <input type="checkbox"/> Yes <input type="checkbox"/> No	About ChildCare: Up to 10 hours early education classrooms for children between 0 to 3 years old. (Monday to Friday – All year round) Is your child applying for this program? <input type="checkbox"/> Yes <input type="checkbox"/> No

Program Options for Preschoolers (3 to 5 years old)

Beacon Hill Site 3327 Beacon Avenue S. Seattle, WA 98144	International District Site 801 South Lane Street Seattle, WA 98104	Lake Washington Site 9061 Seward Park Avenue S. Seattle, WA 98118	Mercy Magnuson Place Early Learning Center 7101 62 nd Ave NE Seattle, WA 98115
Classrooms Available: 3.5 Hours Morning Part Time – Monday to Thursday School Year	Classrooms Available: 6.0 Hours Full Day – Monday to Friday School Year	Classroom Available: 6.0 Hours Full Day – Monday to Thursday All year round	Classrooms Available: 10.0 Hours Extended Day – Monday to Friday All year round
3.5 Hours Afternoon Part Time – Monday to Thursday School Year	6.0 Hours Full Day – Monday to Thursday All year round		10.0 Hours Extended Day – Monday to Friday School Year
6.0 Hours Full Day – Monday to Thursday All year round			
6.0 Hours Full Day – Monday to Friday School Year			
10.0 Hours Extended Day – Monday to Friday All year round			

Please select your first, second, and third option:

1st Option – Site/Center: _____ Classroom: _____

2nd Option – Site/Center: _____ Classroom: _____

3rd Option – Site/Center: _____ Classroom: _____

Acknowledgement of Agreement

To the best of my knowledge, the information on this form is factual and true. Participation in Denise Louie Education Programs is determined by mandated eligibility requirements, including income. Once a child has been determined eligible, should any information provided by parent/guardian and used to determine that eligibility be found to be inaccurate or fraudulent, Denise Louie Education Center will immediately terminate services.

Parent/Guardian Signature: _____

Date: _____

General Information About Our Programs

If you need more information about our programs, tuition, subsidies, or eligibility for services at no cost, please contact our enrollment team:

Phone number: 206-767-8223 | Fax number: 206-767-2919
 Address: 5333 15th Avenue South, Seattle WA 98108
 Visit our webpage www.deniselouie.org

Our programs are funded by **Best Start for Kids of King County, Office of Head Start, DCYF – Washington State, and City of Seattle.**