For Staff Use Only
Child ID #:
_____

Okanogan County Child Development Association

I am interested in the following OCCDA programs (select all that apply):

Ages Prenatal/Birth to 3yrs: [ ] Rural Home Visiting [ ] Early Head Start **Ages 3-5years:** [ ] Head Start [ ] ECEAP

PRENATAL Application			
Prenatal Information for Early Head Start or Rural Home Visiting only (*complete this section and page 2* of this application if you are pregnant or applying for Early Head Start or Rural Home Visiting Program):			
Mother's Name:	**Estimated Due Date:**	**Mother's Date of Birth**	**High Risk Pregnancy?**
			[ ] Yes [ ] No

CHILD Application				
First Name	**Last Name**	**Nickname**	**Date of Birth**	**Gender**
				[ ] Male [ ] Female

Was this child enrolled in Early Head Start, Rural Home Visiting, Head Start or ECEAP Program last Year?
[ ] Yes [ ] No If yes, please check which program: [ ] RHV [ ] EHS [ ] HS [ ] ECEAP

Is your child currently enrolled in any other Early Childhood programs?
[ ] Yes [ ] No If yes, which program? _____

What language(s) does your child speak?	**Child is Hispanic or Latino Origin?** [ ] Yes [ ] No
Race: [ ] American Indian/Alaska Native [ ] White [ ] Asian [ ] Hawaiian/Pacific Islander [ ] Black or African American [ ] Biracial/Multiracial [ ] Unspecified [ ] Other:_____	**Do you think your child has a disability/developmental delay?** [ ] Yes [ ] No **Does your child have any of the following:** [ ] IEP [ ] IFSP [ ] Diagnosed Disability **Provider/School District:** _____
Does your child have Medical Insurance? [ ] Yes [ ] No If yes, name of Insurance Plan: _____ **Type:** [ ] Apple Health/Provider One [ ] Private [ ] Other: _____ **Does your child have a regular doctor?** [ ] Yes [ ] No If yes, name of Doctor/Clinic: _____	**Does your child have Dental Insurance?** [ ] Yes [ ] No If yes, name of Insurance Plan: _____ **Does your child have a regular dentist?** [ ] Yes [ ] No If yes, name of Dentist/Clinic: _____
Does your child take medication for a life threatening health condition? [ ] Yes [ ] No If yes, what is the condition: _____	**Do you have any concerns for your child?** [ ] Yes [ ] No **If yes, please check all that apply:** [ ] Physical Health [ ] Former Foster Child [ ] Dental [ ] Hearing [ ] Speech [ ] Low Birth Weight (5.5lbs or less) [ ] Vision [ ] Allergies [ ] Behavior [ ] Learning Difficulties [ ] Abuse/Neglect [ ] Nutrition/ Eating [ ] Life threatening condition (Asthma, Diabetes, Seizures, etc.) [ ] Expelled from another program due to behavior
If currently in Child Care: Name of Provider: _____ Address: _____ Phone Number: _____	**Does your family receive a childcare subsidy?** [ ] Yes [ ] No If yes, please provide: Subsidy #: _____
Child is: [ ] Biological/Adopted/Step Child [ ] Foster Child [ ] Relative Care [ ] Grandchild [ ] Other: _____	

Is at least one parent/guardian an active duty member serving in the military? [ ] Yes [ ] No

PRENATAL/CHILD Application (second page)

How did you hear about Early Head Start, Head Start, ECEAP, or Rural Home Visiting services?
[ ] Flyer [ ] Website [ ] Agency Referral [ ] Friend/Family [ ] School [ ] Other: _____

Are you and your family staying in a car, park, camping ground, hotel, emergency shelter or transitional housing? [ ] Yes [ ] No	**Do you and your family live with another family due to financial hardship or loss of housing?** [ ] Yes [ ] No [ ] No, but we have been homeless in the last 12 months.
PARENT/GUARDIAN	**PARENT/GUARDIAN**
Relation to child: [ ] Mother [ ] Father [ ] Other **Name:** _____	**Relation to child:** [ ] Mother [ ] Father [ ] Other **Name:** _____
Physical Address: **Mailing Address:**	**Physical Address:** **Mailing Address:**
Primary Phone (Cell/Home): **Work/Message Phone:**	**Primary Phone (Cell/Home):** **Work/Message Phone:**
Date of Birth:	**Date of Birth:**
Language(s) spoken:	**Language(s) spoken:**
Do you require an interpreter to access services? [ ] Yes [ ] No	**Do you require an interpreter to access services?** [ ] Yes [ ] No
Education Level (Check the highest completed): [ ] Grade 6 or less [ ] Grade 10 [ ] GED [ ] Grade 7 [ ] Grade 11 [ ] Some college [ ] Grade 8 [ ] Grade 12 [ ] Tech. Training [ ] Grade 9 [ ] HS Diploma [ ] AA [ ] BA	**Education Level (Check the highest completed):** [ ] Grade 6 or less [ ] Grade 10 [ ] GED [ ] Grade 7 [ ] Grade 11 [ ] Some college [ ] Grade 8 [ ] Grade 12 [ ] Tech. Training [ ] Grade 9 [ ] HS Diploma [ ] AA [ ] BA
Are you currently in school? [ ] Yes [ ] No If yes: [ ] Part time [ ] Full time School: _____	**Are you currently in school?** [ ] Yes [ ] No If yes: [ ] Part time [ ] Full time School: _____
Are you currently working? [ ] Yes [ ] No [ ] Working Full Time (30 hours or more each week) [ ] Working Part Time (less than 30 hours each week) **Name of Employer:** _____ [ ] Seasonally employed [ ] Migrant [ ] Unemployed [ ] Disabled [ ] Retired	**Are you currently working?** [ ] Yes [ ] No [ ] Working Full Time (30 hours or more each week) [ ] Working Part Time (less than 30 hours each week) **Name of Employer:** _____ [ ] Seasonally employed [ ] Migrant [ ] Unemployed [ ] Disabled [ ] Retired

Do you have any concerns/struggles for yourself and/or your family members? [ ] Yes [ ] No
If yes, please check all that apply:
[ ] Housing [ ] Disability/Unable to work [ ] Family Violence [ ] Basic Needs (Food or Shelter) [ ] Legal Issues
[ ] Health Issues [ ] Job/Employment [ ] Drug/Alcohol Issues [ ] Learning Difficulties
[ ] Immigration [ ] Incarcerated Parents [ ] Teen Parent (<17yrs) [ ] Mental Health/Illness/Post-Partum Depression
[ ] CPS Involvement (current/past) [ ] Little or no support from family and friends

Number of People in Family: _____ Ages of other children in the home: _____

Are you receiving a TANF grant? [ ] Yes [ ] No [ ] Previously If yes, DSHS grant number: _____
Are you receiving SNAP? [ ] Yes [ ] No **Does anyone in the household smoke?** [ ] Yes [ ] No
Are you receiving WIC? [ ] Presently [ ] Past [ ] No
Is anyone in your family receiving SSI? [ ] Yes [ ] No If yes, who?_____

I have answered questions truthfully and to the best of my knowledge. I understand the information I have provided is confidential and will not be shared without my permission. If applicable, I give OCCDA permission to contact DSHS and for DSHS to release the amount of TANF benefits receiving. I also authorize OCCDA to verify my child's immunization status with Washington State immunization information system, formally Child Profile.

Date: _____ Parent/Guardian Signature: _____

OCCDA does not discriminate on the basis of race, creed, religion, marital status, sexual orientation, national origin, sex, age, or mental/sensory/physical disability.