Okanogan County Child Development Association

127 North Juniper Street
Omak, WA 98841

Phone: 509.826.2466
Fax: 509.826.3829

We are excited that you are interested in our Early Learning programs. **All programs are at NO COST to the eligible family.**

We serve children and families throughout Okanogan County and Bridgeport. We serve families with the greatest need. We strive to make sure that all families are given a fair opportunity for enrollment.

You will need to give us verification of proof of birth for the child or due date for the pregnant mother. Acceptable copies of proof of birth include:

- Birth certificate, DSHS Verification of Birth, Medical record of Birth or Hospital/Doctor Record
- Washington State identification card, Passport or Visa
- Other legal document
- Acceptable verification to confirm the due date for a pregnant woman is a letter signed by the doctor.

You will need to provide verification of all family income for the past 12 months or previous calendar year. For example:

- Tax Return for the past year
- W-2 Form for the past year
- Wage Stubs for the past 12 months or December paystubs showing end of year gross earnings
- Public assistance (TANF cash or SSI) award letter
- Unemployment Earnings
- Child Support
- Foster Care Benefit Letter
- Employer's statement with total gross earnings for the past 12 months.

We want your child's experience to be positive. Because children learn best when they are healthy, we ask that you bring us copies of:

- ***Shot Record***
- ***Well Child exams (within the past 12 months)***
- ***Dental exams (required for children age three years or older)***

Due to limited space, we are not able to offer enrollment to every family at the start of the year. If your child is not immediately selected at the start of the school year, his/her name will remain on a waiting list. We use the waiting list to enroll qualified families whenever there is an opening.

If you have any questions or need additional help, please call (509) 826-2466 or 1-800-834-2466. We look forward to working with you and your family.

Sincerely,

Mary M. Brown Kencayd
ERSEA Coordinator

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: [ ] Yes [ ] No
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: _____

At least one parent/guardian served or is 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: **Race:** **Hispanic/Latino** [ ]Yes [ ]No	**Date of Birth:** **Race:** **Hispanic/Latino** [ ]Yes [ ]No
Primary Language(s) spoken:	**Primary 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 (<20yrs) [ ] 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 cash grant? [ ] Yes [ ] No **Are you receiving SNAP?** [ ] Yes [ ] No **Is anyone in your family receiving SSI?** [ ] Yes [ ] No If yes, who?_____	**Are you receiving WIC?** [ ] Presently [ ] Past [ ] Never **Does anyone in the household smoke?** [ ] Yes [ ] No

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.