

Okanogan County Child Development Association

127 Juniper Street North
Omak, WA 98841

Phone:509.826.2466
Fax:509.826.3829



We are very excited that you are interested in our Early Learning programs. Okanogan County Child Development Association provides services for pregnant women and children from birth to five years of age. At OCCDA, our goal is to provide quality early childhood education and comprehensive prevention-based services for children ages 0-5, pregnant women, and their families for the benefit of the community. We serve families throughout Okanogan County and residents of Bridgeport, Wa.

All families are eligible and encouraged to apply for our programs and all programs are NO COST. Priority is given to families with the greatest need, such as homeless families, foster children, children with disabilities, and low-income families.

With your completed application, please include the following documents:

- Proof of child's age or estimated delivery date for expectant mothers
- All family income from the previous calendar year or the last 12 months

You can submit your application at one of our centers or at our main office. If you have any questions or need additional assistance, please call (509) 826-2466

Main Office

127 N Juniper
Omak, WA 98841

Okanogan HS

1240 S 2nd
Okanogan, WA

Oroville EHS/RHV

33436 US 97
Oroville, WA

Brewster EHS/RHV/HS

601 West Cliff
Brewster, WA

Omak EHS/RHV/HS

631 W Ridge Dr
Omak, WA

Tonasket HS/ECEAP

114 Locust St
Tonasket, WA

Bridgeport EHS

1440 Columbia Ave
Bridgeport, WA

Oroville HS/ECEAP

1114 Main St.
Oroville, WA

Tonasket EHS

6th W 5th St
Tonasket, WA

Methow Valley HS

18 Twin Lakes Rd.
Winthrop WA 98862

We look forward to working with you and your family!

Sincerely

ERSEA Team (509)-826-2466 Ext. 217, 214



I am interested in the following OCCDA programs (select all that apply)
 Ages Prenatal/Birth to 3yrs: Rural Home Visiting Early Head Start
 Ages 3-5 years Head Start ECEAP

APPLICANT: CHILD PRENATAL

FIRST	LAST	GENDER	BIRTHDATE	Estimated Due Date
		<input type="checkbox"/> M <input type="checkbox"/> F		
RACE	HISPANIC OR LATINO ORIGIN	PREVIOUSLY ENROLLED IN AN EARLY CHILDHOOD EDUCATION PROGRAM?		
<input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Black/ African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		
PRIMARY HEALTH CARE INSURANCE	PRIMARY DOCTOR/CLINIC			
DENTAL INSURANCE	DENTAL CLINIC/DENTIST			

PRIMARY ADULT: RELATION TO CHILD: MOTHER FATHER OTHER

FIRST	LAST	BIRTHDATE		
RACE	HISPANIC OR LATINO ORIGIN	DO YOU NEED AN INTERPRETER TO ACCESS SERVICES?		
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
HIGHEST GRADE COMPLETED	EMPLOYMENT STATUS	CHILD'S RELATIONSHIP	CHECK ALL THAT APPLY:	
<input type="checkbox"/> 12th Grade or Less <input type="checkbox"/> Associate's <input type="checkbox"/> High School Graduate <input type="checkbox"/> Bachelor's <input type="checkbox"/> GED <input type="checkbox"/> Master's <input type="checkbox"/> Some College/TechTraining	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Training or School <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Unemployed	<input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster	CUSTODY <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support	
EMAIL ADDRESS:				

SECONDARY OR OTHER ADULT: RELATION TO CHILD: MOTHER FATHER OTHER

FIRST NAME	LAST NAME	BIRTHDATE		
RACE	HISPANIC OR LATINO ORIGIN	DO YOU NEED AN INTERPRETER TO ACCESS SERVICES?		
<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
HIGHEST GRADE COMPLETED	EMPLOYMENT STATUS	CHILD'S RELATIONSHIP	CHECK ALL THAT APPLY:	
<input type="checkbox"/> 12th Grade or Less <input type="checkbox"/> Associate's <input type="checkbox"/> High School Graduate <input type="checkbox"/> Bachelor's <input type="checkbox"/> GED <input type="checkbox"/> Master's <input type="checkbox"/> Some College/TechTraining	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Training or School <input type="checkbox"/> Retired or Disabled <input type="checkbox"/> Unemployed	<input type="checkbox"/> Biological/Adopted/Step <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Relative <input type="checkbox"/> Foster	CUSTODY <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support	
EMAIL ADDRESS:				

Family Information						
PHYSICAL ADDRESS			CITY	STATE	ZIP CODE	
IS YOUR PHYSICAL ADDRESS THE SAME AS YOUR MAILING ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO						
MAILING ADDRESS			CITY	STATE	ZIP CODE	
PHONE NUMBER(S)	TYPE (CHECK ONE)		NOTES (EXTENSION, BEST TIME TO CALL)		OPT IN FOR TEXT MESSAGE?	
	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OTHER _____				<input type="checkbox"/> YES <input type="checkbox"/> NO	
	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OTHER _____				<input type="checkbox"/> YES <input type="checkbox"/> NO	
PRIMARY LANGUAGE AT HOME	HOMELESS FAMILY	HOMELESS IN THE PAST 12 MONTHS	REFERRED BY CHILD WELFARE AGENCY	RECEIVING SNAP	WIC	TANF
<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PAST
DO YOU HAVE ANY CONCERNS/STRUGGLES FOR YOURSELF AND/OR YOUR FAMILY MEMBERS? IF YES PLEASE CHECK ALL THAT APPLY:						
<input type="checkbox"/> HOUSING <input type="checkbox"/> DISABILITY/UNABLE TO WORK <input type="checkbox"/> HEALTH ISSUES <input type="checkbox"/> CPS INVOLVEMENT (CURRENT/PAST) <input type="checkbox"/> JOB/EMPLOYMENT <input type="checkbox"/> INCARCERATED PARENTS <input type="checkbox"/> FAMILY VIOLENCE <input type="checkbox"/> DRUG/ALCOHOL ISSUES <input type="checkbox"/> LEARNING DIFFICULTIES						
<input type="checkbox"/> LITTLE OR NO SUPPORT FROM FAMILY AND FRIENDS <input type="checkbox"/> BASIC NEEDS (FOOD OR SHELTER) <input type="checkbox"/> MENTAL HEALTH/ILLNESS/POSTPARTUM DEPRESSION <input type="checkbox"/> FIRST TIME PARENT <input type="checkbox"/> LEGAL ISSUES <input type="checkbox"/> IMMIGRATION <input type="checkbox"/> PREGNANCY/HIGH RISK/TEEN PREGNANCY <input type="checkbox"/> SINGLE PARENT						
DOES YOUR FAMILY RECEIVE A CHILD CARE SUBSIDY? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS YOUR FAMILY MOVED IN THE LAST 12 MONTHS FOR WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	DOES ANYONE IN THE HOUSEHOLD SMOKE OR VAPE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS YOUR CHILD CURRENTLY IN CHILD CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF PROVIDER: _____ ADDRESS: _____ PHONE NUMBER: _____			
AT LEAST ONE PARENT/GUARDIAN IS AN ACTIVE MEMBER OF THE MILITARY OR IS A MILITARY VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO						

<p>I have answered all 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 to release the amount of TANF benefits I am receiving. I also authorize OCCDA to verify my child's immunization status with Washington State Immunization Information System, formerly Child Profile.</p>
<p>Date: _____ Parent/Guardian Signature: _____</p> <p><i>OCCDA does not discriminate on the basis of race, creed, religion, marital status, sexual orientation, national origin, gender, age, or mental/sensory/physical disability.</i></p>

Child Name/CP # _____

Child Health Questionnaire	Mark One	
	YES	NO
Does your child have a diagnosed disability?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have an IEP or IFSP? If you marked yes please list the provider/school District: _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any learning difficulties or do you suspect a developmental delay?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems: Does your child seem to favor one ear over the other, seem to hear you if you speak in a whisper, make you repeat yourself, or talk loudly?	<input type="checkbox"/>	<input type="checkbox"/>
Speech/Language: Does your child speak as well as other children the same age?	<input type="checkbox"/>	<input type="checkbox"/>
Vision: Does your child seem to have difficulty seeing things far away, have eyes turned in or out, squint, or wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Physical Health Problems or concerns? (Eating, Behavior, Physical Conditions; Asthma, Diabetes, Heart Problems, Seizures)	<input type="checkbox"/>	<input type="checkbox"/>
Does your child take medication for a life-threatening health condition?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any Allergies? (Foods, seasonal, bees, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Does your Child use any medication for Allergy problems? (Epi-Pen, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Dental: Has your child been seen by a dentist?		
Was your child born preterm (37 weeks or less) with a birth weight of (5.5Lbs or less)?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child been expelled from another program due to behavioral issues?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns for your child due to behavior?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child experienced Abuse or Neglect?	<input type="checkbox"/>	<input type="checkbox"/>

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____