Okanogan County Child Development Association

Children - Families - Families - Community - Community

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
		□ M □ F		

RACE	HISPANIC OR LATINO ORIGIN	PREVIOUSLY ENROLLED IN AN EARLY CHILDHOOD EDUCATION PROGRAM?
□ Asian □ Black/ African American □ American Indian/Alaska Native □ Hawaiian/Pacific Islander □ Other: _____ □ Multi-Racial □ White □ Decline to Answer	□ Yes □ No	□ YES □ NO □ 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?
□ Asian □ Black/African American □ White □ Other:_____ □ American Indian/Alaska Native □ Hawaiian/Pacific Islander □ Multi-Racial □ Decline to answer	□ Yes □ No	□ Yes □ No

HIGHEST GRADE COMPLETED	EMPLOYMENT STATUS	CHILD'S RELATIONSHIP	CHECK ALL THAT APPLY:
□ 12th Grade or Less □ High School Graduate □ GED □ Some College/TechTraining □ Associate's □Bachelor's □ Master's	□ Full Time □ Part Time □ Seasonal □ Training or School □ Retired or Disabled □ Unemployed	□ Biological/Adopted/Step □ Grandchild □ Other Relative □ Foster	CUSTODY □ Yes □ No □ Lives with Family □ Provides Financial Support

EMAIL ADDRESS: **PHONE NUMBER:** **TEXT:** □ YES □ NO

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?
□ Asian □ Black □ White □ Other: _____ □ American Indian/Alaska Native □ Hawaiian/Pacific Islander □ Multi-Racial □ Decline to answer	□ Yes □ No	□ Yes □ No

HIGHEST GRADE COMPLETED	EMPLOYMENT STATUS	CHILD'S RELATIONSHIP	CHECK ALL THAT APPLY:
□ 12th Grade or Less □ High School Graduate □ GED □ Some College/TechTraining □ Associate's □Bachelor's □ Master's	□ Full Time □ Part Time □ Seasonal □ Training or School □ Retired or Disabled □ Unemployed	□ Biological/Adopted/Step □ Grandchild □ Other Relative □ Foster	CUSTODY □ Yes □ No □ Lives with Family □ Provides Financial Support

EMAIL ADDRESS: **PHONE NUMBER:** **TEXT:** □ YES □ NO

Family Information

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

IS YOUR PHYSICAL ADDRESS THE SAME AS YOUR MAILING ADDRESS? □ YES □ NO

MAILING ADDRESS	CITY	STATE	ZIP CODE

PRIMARY LANGUAGE AT HOME	HOMELESS FAMILY	HOMELESS IN THE PAST 12 MONTHS	REFERRED BY CHILD WELFARE AGENCY	RECEIVING SNAP	WIC	TANF
□ ENGLISH □ SPANISH □ OTHER _____	□ YES □ NO	□ YES □ NO	□ YES □ NO	□ YES □ NO	□ YES □ NO	□ YES □ NO □ PAST

DO YOU HAVE ANY CONCERNS/STRUGGLES FOR YOURSELF AND/OR YOUR FAMILY MEMBERS?
IF YES PLEASE CHECK ALL THAT APPLY:

- □ HOUSING
- □ DISABILITY/UNABLE TO WORK
- □ HEALTH ISSUES
- □ CPS INVOLVEMENT (CURRENT/PAST)
- □ JOB/EMPLOYMENT
- □ INCARCERATED PARENTS
- □ FAMILY VIOLENCE
- □ DRUG/ALCOHOL ISSUES
- □ LEARNING DIFFICULTIES
- □ LITTLE OR NO SUPPORT FROM FAMILY AND FRIENDS
- □ BASIC NEEDS (FOOD OR SHELTER)
- □ MENTAL HEALTH/ILLNESS/POSTPARTUM DEPRESSION
- □ FIRST TIME PARENT
- □ LEGAL ISSUES
- □ PREGNANCY/HIGH RISK/TEEN PREGNANCY
- □ SINGLE PARENT
- □ PARENT/GUARDIANS WORK OUTSIDE THE HOME
- □ MORE THAN 1 CHILD UNDER THE AGE OF 6 YEARS OLD

ALL INFORMATION SHARED IS CONFIDENTIAL AND ONLY USED AS QUALIFYING CRITERIA.

DOES YOUR FAMILY RECEIVE A CHILD CARE SUBSIDY?	HAS YOUR FAMILY MOVED IN THE LAST 12 MONTHS FOR WORK?	DOES ANYONE IN THE HOUSEHOLD SMOKE OR VAPE?	IS YOUR CHILD CURRENTLY IN CHILD CARE?
□ YES □ NO	□ YES □ NO	□ YES □ NO	□ YES □ NO NAME OF PROVIDER: _____ ADDRESS: _____ PHONE NUMBER: _____

AT LEAST ONE PARENT/GUARDIAN IS AN ACTIVE MEMBER OF THE MILITARY OR IS A MILITARY VETERAN?
□ YES □ NO

HOW DID YOU HEAR ABOUT OUR SERVICES

□ SOCIAL MEDIA □ FLYER □ COMMUNITY EVENT □ FRIEND □ PROFESSIONAL REFERRAL □ OTHER _____

Event Name:

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.

Date: _____ **Parent/Guardian Signature**: _____

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

Child Name/CP # _____

Child Health Questionnaire	Mark One YES	NO
Does your child have a diagnosed disability?	☐	☐
Does your child have an IEP or IFSP? If you marked yes please list the provider/school District: _____	☐	☐
Does your child have any learning difficulties or do you suspect a developmental delay?	☐	☐
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?	☐	☐
Speech/Language: Does your child speak as well as other children the same age?	☐	☐
Vision: Does your child seem to have difficulty seeing things far away, have eyes turned in or out, squint, or wear glasses?	☐	☐
Physical Health Problems or Concerns? (Eating, Behavior, Physical Conditions; Asthma, Diabetes, Heart Problems, Seizures)	☐	☐
Does your child take medication for a life-threatening health condition?	☐	☐
Does your child have any Allergies? (Foods, seasonal, bees, etc.)	☐	☐
Does your Child use any medication for Allergy problems? (Epi-Pen, etc**.)**	☐	☐
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)?	☐	☐
Has your child been expelled from another program due to behavioral issues?	☐	☐
Do you have any concerns for your child due to behavior?	☐	☐
Has your child experienced Abuse or Neglect?	☐	☐

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____