

OCCDA Head Start/Early Head Start/ECEAP Application

PO Box 1844; 101 West 4th Ave., Omak WA 98841

(800) 834-2466 or (509) 826-2466

Child Information	Child's Name: (Last, First) If applying for an Unborn Child <input type="checkbox"/>		Date of Birth or Estimated Due Date:	
	Home Phone #:		Message #:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Physical Address:		City:	
			Zip Code:	
	We are homeless. (According to the McKinney-Vinto Act, this means your family is staying in a car, park, campground or hotel, emergency shelter, or your family is living with another family temporarily; documentation of homelessness may have to be received before enrollment): <input type="checkbox"/> No <input type="checkbox"/> Yes			
	What language(s) does your child speak? (Primary)		(Secondary)	
Child's Ethnicity: Check ONE Box <input type="checkbox"/> <input type="checkbox"/> Hispanic <input type="checkbox"/> <input type="checkbox"/> Non Hispanic				
Child's Race(s): Check ALL that apply: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> <input type="checkbox"/> Asian <input type="checkbox"/> <input type="checkbox"/> Black/African American <input type="checkbox"/> <input type="checkbox"/> Caucasian/White <input type="checkbox"/> <input type="checkbox"/> Hawaiian/Pacific Islander				
Is this child on an IEP or IFSP? <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Pending <input type="checkbox"/> Yes, name the school district or agency:				
Family Information	Child lives with: <input type="checkbox"/> One Parent/Guardian <input type="checkbox"/> Two Parents/Guardians Name(s):			
	Number in Family:		Ages of other Children in the home:	
	Child is: (circle one) Your Birth (Biological) or Adopted Child Foster Child Grandchild Other:			
	Are there any court orders affecting this child? (restraining orders, foster care, visitation, custody, etc) <input type="checkbox"/> No <input type="checkbox"/> Yes			
	Child Support? <input type="checkbox"/> No <input type="checkbox"/> Yes Amount: _____		<i>(Note: If Yes, a copy will be needed)</i>	
	Is anyone in your family receiving SSI? <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Yes If yes, who receives it?		Are you receiving WIC? <input type="checkbox"/> <input type="checkbox"/> Currently <input type="checkbox"/> <input type="checkbox"/> Previously <input type="checkbox"/> Never	
	Are you receiving TANF? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, DSHS case #:		Food Stamps? <input type="checkbox"/> No <input type="checkbox"/> Yes Case #:	
		Tribal Commodities? <input type="checkbox"/> No <input type="checkbox"/> Yes Case #:		
Does your family currently receive a childcare subsidy? <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Yes Subsidy #:				
Parent/Guardian Information	PARENT/GUARDIAN 1		PARENT/GUARDIAN 2	
	Mother/Father/Other (please circle)		Mother/Father/Other (please circle)	
	Name:		Name:	
	Mailing Address:		Mailing Address: (if different than Parent/Guardian 1)	
	Home/Cell Phone:		Home/Cell Phone:	
	Work/Message Phone:		Work/Message Phone:	
	Your Date of Birth:		Your Date of Birth:	
	Language(s) you speak:		Language(s) you speak:	
	Education Level (check highest completed) <input type="checkbox"/> <input type="checkbox"/> 6th grade or less <input type="checkbox"/> <input type="checkbox"/> Some College <input type="checkbox"/> <input type="checkbox"/> 7th - 9th grade <input type="checkbox"/> <input type="checkbox"/> 2-year Degree <input type="checkbox"/> <input type="checkbox"/> 10th - 12th grade <input type="checkbox"/> <input type="checkbox"/> 4-year Degree <input type="checkbox"/> <input type="checkbox"/> High School Diploma <input type="checkbox"/> <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/> GED		Education Level (check highest completed) <input type="checkbox"/> <input type="checkbox"/> 6th grade or less <input type="checkbox"/> <input type="checkbox"/> Some College <input type="checkbox"/> <input type="checkbox"/> 7th - 9th grade <input type="checkbox"/> <input type="checkbox"/> 2-year Degree <input type="checkbox"/> <input type="checkbox"/> 10th - 12th grade <input type="checkbox"/> <input type="checkbox"/> 4-year Degree <input type="checkbox"/> <input type="checkbox"/> High School Diploma <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> GED	
	Education or Training Currently Involved in (Check all that apply)			
	<input type="checkbox"/> <input type="checkbox"/> ESL <input type="checkbox"/> <input type="checkbox"/> High School Completion <input type="checkbox"/> <input type="checkbox"/> GED <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> Voc/Tech Program <input type="checkbox"/> <input type="checkbox"/> None <input type="checkbox"/> <input type="checkbox"/> College		<input type="checkbox"/> <input type="checkbox"/> ESL <input type="checkbox"/> <input type="checkbox"/> High School Completion <input type="checkbox"/> <input type="checkbox"/> GED <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> Voc/Tech Program <input type="checkbox"/> <input type="checkbox"/> None <input type="checkbox"/> <input type="checkbox"/> College	

Parent/Guardian Information	PARENT/GUARDIAN 1	PARENT/GUARDIAN 2
	Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Looking for Work <input type="checkbox"/> Part-time <input type="checkbox"/> Not Looking for Work	Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Looking for Work <input type="checkbox"/> Part-time <input type="checkbox"/> Not Looking for Work
	Migrant/seasonal farm worker? <input type="checkbox"/> No <input type="checkbox"/> Yes	Migrant/seasonal farm worker? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Parent enrolled in medical/dental plan (check all that apply) <input type="checkbox"/> DSHS Medical <input type="checkbox"/> Private/employer medical <input type="checkbox"/> Coupons insurance <input type="checkbox"/> TriCare (Military) <input type="checkbox"/> Private/Employer dental <input type="checkbox"/> Other: insurance <input type="checkbox"/> No Medical insurance <input type="checkbox"/> Indian Health <input type="checkbox"/> No dental insurance	Parent enrolled in medical/dental plan (check all that apply) <input type="checkbox"/> DSHS Medical <input type="checkbox"/> Private/employer medical <input type="checkbox"/> Coupons insurance <input type="checkbox"/> TriCare (Military) <input type="checkbox"/> Private/Employer dental <input type="checkbox"/> Other: insurance <input type="checkbox"/> No Medical insurance <input type="checkbox"/> Indian Health <input type="checkbox"/> No dental insurance
	Parent has primary health care provider or medical home? <input type="checkbox"/> No <input type="checkbox"/> Yes	Parent has primary health care provider or medical home? <input type="checkbox"/> No <input type="checkbox"/> Yes
Child Medical Information	Does your child have medical insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Health Plan: Type: <input type="checkbox"/> DSHS Medical Coupons <input type="checkbox"/> Apple Health <input type="checkbox"/> IHS <input type="checkbox"/> Private <input type="checkbox"/> Other:	
	Does your child have dental insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Health Plan: Type: <input type="checkbox"/> DSHS Medical Coupons <input type="checkbox"/> Apple Health <input type="checkbox"/> IHS <input type="checkbox"/> Private <input type="checkbox"/> Other:	
	Does your child have a primary Health Care Provider/medical home? <input type="checkbox"/> No <input type="checkbox"/> Yes Provider's Name or Medical Home:	
	<i>Early Head Start, Head Start, and ECEAP require that children are up-to-date on well child and dental exams and receive ongoing preventative health care.</i>	
Child/Family Concerns	Does your child have a diagnosed medical condition or diagnosed allergy? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please explain:</i>	
	Do you have concerns for your child? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please check all that apply)</i> <input type="checkbox"/> Dental Health <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> Speech or Hearing <input type="checkbox"/> Behavior <input type="checkbox"/> Special Health Care Needs <input type="checkbox"/> Physical Health <input type="checkbox"/> Nutrition/Eating <input type="checkbox"/> Abuse/Neglect <input type="checkbox"/> Vision <input type="checkbox"/> Former Foster Child	
	Do you have concerns for yourself or other family members? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please check all that apply)</i> <input type="checkbox"/> Housing <input type="checkbox"/> Job/Employment <input type="checkbox"/> Disability/Unable to work <input type="checkbox"/> Family Violence <input type="checkbox"/> Learning Difficulties <input type="checkbox"/> Drug/Alcohol Issues <input type="checkbox"/> Immigration <input type="checkbox"/> Mental Health/Illness <input type="checkbox"/> Military Deployment <input type="checkbox"/> Legal Issues <input type="checkbox"/> Parent Incarcerated <input type="checkbox"/> Health Issues <input type="checkbox"/> Teen Parent	
Note: All reasonable efforts are made to ensure that bus routes are established to accommodate as many children as possible.		
Transp Info	My child would be picked up at: Address Phone:	
	My child would be dropped off at: Address Phone:	
Other Info	Have you been referred from someone else to our agency? <input type="checkbox"/> No <input type="checkbox"/> Yes, please check all that apply <input type="checkbox"/> CPS involvement <input type="checkbox"/> Referral from Other Agency <input type="checkbox"/> Other:	
Did your child receive Early Head Start, Head Start, or ECEAP services in the previous year? <input type="checkbox"/> No <input type="checkbox"/> Yes Has child received EHS, HS, or ECEAP services from another agency this year? <input type="checkbox"/> No <input type="checkbox"/> Yes, Location:		

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

I understand that the information I have provided on this application is confidential and will not be shared without my permission. If applicable, I give OCCDA permission to contact DSHS to verify my benefits and to verify my child's immunization status with Washington State Child Profile.

 Parent/Guardian Signature
 E-mail (optional): _____

 Date