Oahe Child Development Center, Inc.

P.O. Box 907
2307 E. Capitol Avenue
Pierre, South Dakota 57501

Phone: (605) 224-6603
Fax #: (605) 224-0850

APPLICATION

We are pleased that you are applying for our program! Oahe Child Development Center (OCDC) provides a comprehensive program that includes early childhood education, health, mental health, nutrition, family partnerships, and advocacy services for enrolled families.

To complete the application process, OCDC Head Start/Early Head Start will need the following information:

- ☐ **COMPLETED APPLICATION**
- ☐ **FAMILY'S PROOF OF INCOME (In order to verify income, please bring a 1040 Tax Statement, pay stubs, W-2 forms and-or proof of child support.)**
- ☐ **CHILD'S BIRTH RECORD**
- ☐ **IMMUNIZATION RECORD (Please see back side of this page for program requirements.)**

***PLEASE NOTE*: CHILD MUST BE UP-TO-DATE ON ALL IMMUNIZATIONS TO BE CONSIDERED FOR FULL DAY CLASS ENROLLMENT AS PER SD CHILDCARE LICENSURE REQUIREMENTS.**

Once your application has been returned and income has been verified, you or your child will be placed on a waiting list. We will start accepting income eligible children in the middle of May. Over income families will be notified starting the third week in July. If you do not receive notification during this time, you or your child will remain on the wait list until an opening occurs. During the school year, all applications will be reviewed at the time of an opening.

If you have any questions please call me at 605-280-8262 or 605-224-6603.

Cindy Malsam

4/21/2020

Family Service Specialist
Oahe Child Development Center

Recommended Immunization Schedule

Vaccine	Birth	1 Mo	2 Mo	4 Mo	6 Mo	12 Mo	15 Mo	18 Mo	19-23 Mo	4-6 Yr
Hepatitis B (Hep B)	#1	#2			#3					
Diphtheria, Tetanus, Pertussis (DTP)			#1	#2	#3		#4			#5
Haemophilus influenzae Type b (Hib)			#1	#2	#3*	#4				
Inactivated Poliovirus			#1	#2	#3					#4
Measles, Mumps, Rubella (MMR)						#1				#2
Varicella						#1				#2
Hepatitis A						#1 & #2 (6 months apart)				
Pneumococcal (PVC)			#1	#2	#3	#4				
		= Immunization is to be given within this range of time								

IMMUNIZATION REQUIREMENTS – effective September 2016

Combination Vaccines Often Seen on Immunization Records:

Pediarix = DTaP, Hep B, Polio
Pentacel = DTaP, Hib, Polio
Kinrix = DTaP, Polio
MMRV = Varicella, MMR

***** NOTE: The Pedvax or ComVax Hib is 3 doses, with the 6-month immunization not required. All other Hib series are 4 doses using the schedule above.

4/21/2020

OAHE CHILD DEVELOPMENT CENTER

Child Application

Early Head Start / Head Start

PO Box 907 - 2307 E. Capitol Pierre, SD 57501
Phone: 605-224-6603 Fax: 605-224-0850

PLEASE COMPLETE ALL AREAS OF THIS APPLICATION.

OFFICE USE ONLY Date Received: _____

EHS: _____ HS: _____

IMMUNES: _____1/2 DAY _____ FULL DAY

ENCODED _____ County _____

Applicant Information (Child)

_____
First Name MI Last Name

Date of Birth:
_____/_____/_____

☐Male ☐Female

Has the applicant been enrolled in a Head Start/Early Head Start program before? _____
If so, where? _____
When? _____

Living Address			**Mailing Address**		
Street:			Street/PO Box:		
Town/City:	State:	Zip Code:	Town/City:	State:	Zip Code:
County:			School District:		

Applicant lives with: *(check all that apply)*

☐Mother ☐Step Father
☐Father ☐Step Mother
☐Foster Parent ☐Legal Guardian
☐Grandparent(s) ☐Other Relative
☐Other (specify) _____
_____

Language(s) spoken in the child's home?

Primary: _____

Secondary: _____

How well does the applicant speak English?

*****Race Key at Bottom of page**

	Race		*Circle one*	
Applicant		Hispanic?	Y ☐	N ☐
Primary Guardian		Hispanic?	Y ☐	N ☐
Secondary Guardian		Hispanic?	Y ☐	N ☐

Primary Parent/Guardian

First Name Middle Name Last Name

Date of Birth: Relationship to Child:

Telephone Number Information:

Home/Cell _____

Work: _____ Other: _____

E-mail: _____

Secondary Parent/Guardian

First Name Middle Name Last Name

Address:

Date of Birth: Relationship to Child

Telephone Number Information:

Home/Cell: _____ Work: _____

E-mail: _____

Please list all OTHER persons living in the home

First Name	Last Name	Date of Birth	Relationship to Child	Race

Primary Parent/Guardian Employment and Education

Employment:

☐Full time ☐Part time ☐Seasonal ☐Unemployed

Employer Name: _____

Are you attending job training? ☐Yes ☐No

Are you in school? ☐Yes ☐No

If yes, Where? _____

Are you active in any branch of the United States Military? ☐Yes ☐No

Are you a **Veteran** of the United States Military? ☐Yes ☐No

Highest level of education completed:

☐9th or less ☐10th ☐11th ☐HS Graduate
☐Some college ☐BS/BA ☐Associate's Degree
☐2 year college ☐Master's ☐Advanced ☐Vocational
☐Doctorate ☐Other _____

Secondary Parent/Guardian Employment and Education

Employment:

☐Full time ☐Part time ☐Seasonal ☐Unemployed

Employer Name: _____

Are you attending job training? ☐Yes ☐No

Are you in school? ☐Yes ☐No

If yes, Where? _____

Are you active in any branch of the United States Military? ☐Yes ☐No

Are you a **Veteran** of the United States Military? ☐Yes ☐No

Highest level of education completed:

☐9th or less ☐10th ☐11th ☐HS Graduate
☐Some college ☐BS/BA ☐Associate's Degree
☐2 year college ☐Master's ☐Advanced ☐Vocational
☐Doctorate ☐Other _____

*****Race Key: American Indian (AI), Asian (AS), Black or African American (B), Native Hawaiian (NH), White (W),Biracial / Multi-Racial (MR), Other (O)**

Does your family receive, (or is certified for), daycare assistance?	☐ **No** ☐ **Yes**
Typical Work Schedule (if applicable) of Primary Parent/Guardian	**Typical Work Schedule (if applicable) of Secondary Parent/Guardian**
_____ _____	_____ _____

Option Information *****Please note these options are only for Center Based Children ages 3-5 in the Pierre Center*****

Please check the option(s) you would prefer your child in. We only have a certain number of slots for each option and cannot guarantee any enrollment slot.

- ☐ AM ½ day class Monday-Thursday, (8am-11:30am)
- ☐ PM ½ day class Monday-Thursday, (12pm-3:30pm)
- ☐ Full day class Monday-Thursday and some Fridays (8am-3pm)
- ☐ After school program that operates 3:00pm-5:15pm Monday-Thursday and some Fridays

Family Resources Information

Does your family receive any of the following types of services or financial assistance? (Please indicate all that apply):

- ☐ SNAP (Food Stamps)
- ☐ WIC
- ☐ Public Assistance – TANF
- ☐ Foster Care/Adoption subsidy
- ☐ Unemployment Insurance
- ☐ Supplemental Security Income (SSI)
- ☐ Child Support/Alimony
- ☐ Financial Aid/Student Loans

Are there any other concerns or family situations that we should be aware of to help meet your child's needs? (Such as a recent divorce, move, parental health, counseling, parent absent due to incarceration or military duty, etc.)

☐ No ☐ Yes If yes, please explain: _____ _____ _____

Custodial Information:

- ☐ Joint Custody – Both biological parents
- ☐ Joint Custody – other: Explain _____
- ☐ Sole Custody
- ☐ Physical Custody: explain who has legal custody _____

Is there a protection or restraining order regarding the child?

- ☐ No
- ☐ Yes, please explain and provide us with a copy

Are there special visitation orders we should be aware of?

- ☐ No
- ☐ Yes, please explain and provide us with a copy
  Foster Care/Custody of State of South Dakota
  Caseworker: _____ Phone: _____

Additional Information:

Is anyone in your household currently pregnant?

☐ No ☐ Yes

If yes, would you like information or an application about the Early Head Start Services for expectant families?

- ☐ Application
- ☐ Information
- ☐ Both
- ☐ No thank you

How Did You Hear About Us:

- ☐ OCDC Website
- ☐ Facebook /Social Media
- ☐ Newspaper
- ☐ Personal Contact
- ☐ TV/Radio announcement

Were You Referred by Another Agency:

- ☐ Child Welfare Agency
- ☐ Public School/EC Program
- ☐ Health care provider/dentist
- ☐ Other _____
- ☐ WIC Office/County Health

Special Needs/Services:

Does the applicant have any special needs? ☐ No ☐ Yes If yes, please describe: _____ _____

Is the applicant receiving any special services or currently on an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? (Examples: medical, speech therapy, physical therapy, occupational therapy, counseling, etc.)

- ☐ No
- ☐ Yes If yes, please describe and provide name and address of service provider: _____

Provider: _____ Phone: _____ Address: _____

BEFORE ACCEPTANCE INTO OUR PROGRAM, INCOME MUST BE VERIFIED BY AUTHORIZED OCDC STAFF

Head Start Performance Standards require your child to have up-to-date "well child" AND dental exams.

The statements and information on this application are true and accurate to the best of my knowledge.

_____

Parent/Guardian Date Parent/Guardian Date