



Oahe Child Development Center

Expectant Mother Application

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: _____

ENCODED _____

Applicant Information

First Name	MI	Last Name	<u>Date of Birth:</u> / /	<u>Applicant's Due Date:</u> / /
Living Address			Mailing Address - If different than living address	
Street:			Street/PO Box:	
Town/City:	State:	Zip Code:	Town/City:	State:
County:			Zip Code:	
School District:				
Applicant lives with: (check all that apply)		<i>Language(s) spoken in your home?</i> Primary: _____ Secondary: _____ How well do you speak English? _____		Race ***Race Key Applicant _____ Secondary Adult _____
<input type="checkbox"/> Mother <input type="checkbox"/> Stepfather <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Other (Specify) _____				

*****Race Key: American Indian or Alaskan Native, Asian, Black or African American, Hispanic or Latino, Middle Eastern or North African, Native Hawaiian or Pacific Islander, White, Multiracial and/or Multiethnic, or Unspecified**

Applicant Contact Information

Home/Cell: _____	First Name _____	Middle Name _____	Last Name _____
Work: _____	Address: _____		
Other: _____	Date of Birth: _____	Relationship to Applicant: _____	
E-mail: _____	Telephone Number Information: Home/Cell: _____ Work: _____ E-mail: _____		

Please list all OTHER person(s) living in the home

First Name	Last Name	Date of Birth	Relationship to Applicant	Race

Applicant Employment and Education

Employment: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed		Employment: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed	
Employer Name: _____		Employer Name: _____	
Are you in job training? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you in job training? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Where? _____		If yes, Where? _____	
Are you active in any branch of the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you active in any branch of the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a Veteran of the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a Veteran of the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Highest level of education completed: <input type="checkbox"/> 9th or less <input type="checkbox"/> 10 th <input type="checkbox"/> 11 th <input type="checkbox"/> HS Graduate <input type="checkbox"/> GED <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Associate's Degree <input type="checkbox"/> College or Advanced Training <input type="checkbox"/> Master's <input type="checkbox"/> Training Certificate <input type="checkbox"/> Doctorate <input type="checkbox"/> Other			
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Family Resources Information

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

<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> Supplemental Security Income (SSI)
<input type="checkbox"/> WIC	<input type="checkbox"/> None Listed
<input type="checkbox"/> Public Assistance – TANF	

Is your family currently in crisis?

No Yes

If yes, please explain: _____

Are there any other concerns or family situations that we should be aware of to help meet your needs?

(Such as a recent divorce, parental health, recent move, counseling, parent absent due to incarceration or active military duty, etc.)?

No If yes, please explain: _____

Yes _____

How Did You Hear About Us:	Were You Referred by Another Agency:
<input type="checkbox"/> OCDC Website <input type="checkbox"/> Newspaper <input type="checkbox"/> TV/Radio announcement <input type="checkbox"/> Facebook /Social Media <input type="checkbox"/> Personal Contact	<input type="checkbox"/> Child Welfare Agency <input type="checkbox"/> Health care provider/dentist <input type="checkbox"/> WIC Office/County Health <input type="checkbox"/> Public School/EC Program <input type="checkbox"/> Other _____

Health Care Coverage Information:

CHIP/Medicaid Indian Health Services Tri-Care Private Health Insurance No Medical Coverage

Special Needs/Services:

Do you have any special needs?

No Yes

If yes, please describe: _____

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

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

Applicant Signature

Date

Signature

Date

This institution is an equal opportunity provider