MALHEUR COUNTY CHILD DEVELOPMENT CENTER
OREGON PRE-KINDERGARTEN PROGRAM
790 SW 7TH PLACE, ONTARIO, OR 97914
PHONE: (541) 889-2393 | FAX: (541) 889-7137 | www.mccdc.org

ELIGIBILITY APPLICATION

This application will be used to determine your child's eligibility for Head Start. Completed applications must be brought in person to one of MCCDC's centers or to our Central Office, along with verification of your child's birth date, immunization record and proof of household income for the past 12 months or the last tax year. Please contact our Central Office if you have any questions.

Primary Parent/Guardian Name _____ Birth Date _____

Child Name _____ Birth Date _____

General Information

Living Address: City: State: Zip Code: County:

Mailing Address (If Different): City: State: Zip Code:

Phone Number(s): (Check 1 primary number)

☐ Cell / Mobile #: ☐ Work #:

☐ Home #: ☐ Other #:

Number in Household ___ Number in Family ___ Total Number of Children ___ Number Ages 0-3 ___ Number Ages 4-5 ___

Parental Status (In Home): ☐ One ☐ Two

Primary Language in Home:

Program Preference:

☐ Vale @ Home Based; Ages 0-3
☐ Vale @ School; Ages 3-5
☐ Vale @ School; Ages 0-3
☐ Ontario @ Home Based; Ages 0-3
☐ Ontario @ School; Ages 3-5
☐ Ontario @ School; Ages 0-3

Family Information

Receiving TANF (i.e. cash grant, daycare assistance, etc.) ☐ Yes ☐ No
If yes, provide documentation.

WIC ID: _____

Family Member in household receives SSI ☐ Yes ☐ No

_____
If yes, name of person receiving SSI (provide documentation)
Relationship to child:

Do you receive SNAP benefits? ☐ Yes ☐ No

Do you have any specific needs or crisis? (Please check all that apply)
☐ Homeless ☐ Other Housing Crisis (such as no hot water or severely overcrowded) ☐ Domestic Violence ☐ Child Abuse ☐N/A

Are you currently working with any community agency? ☐ Yes ☐ No If Yes, check all that apply:
☐ Lifeways ☐ DHS ☐ The Family Place ☐ ESD ☐ School District ☐ OHDC ☐ Child Welfare ☐ Other _____

Does your child currently have a doctor? ☐ Yes ☐ No If yes, list:

Doctor _____ Phone Number _____

Does your child currently have a dentist? ☐ Yes ☐ No If yes, list:

Dentist _____ Phone Number _____

Primary Adult

Last Name:	First Name:	Middle Name:	Preferred Name:
Suffix:	Birth Date:	Gender: ☐ M / ☐ F	Relationship to child:

☐ Lives with Family ☐ Provides Financial Support
☐ Teen Parent ☐ First Time Parent

Email Address: _____

Employment:
☐ Full Time ☐ Part Time
☐ Full Time & Training ☐ Part Time & Training
☐ Training or School ☐ Seasonally Employed
☐ Retired or Disabled ☐ Unemployed

Secondary Adult

Last Name:	First Name:	Middle Name:	Preferred Name:
Suffix:	Birth Date:	Gender: ☐ M / ☐ F	Relationship to child:

☐ Lives with Family ☐ Provides Financial Support
☐ Teen Parent ☐ First Time Parent

Email Address: _____

Employment:
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Child

Last Name: First Name: Middle Name: Preferred Name: Suffix: Birth Date: Gender: ☐ M / ☐ F

SSN: Medicaid Eligible: ☐ Yes ☐ No Medicaid #:

Primary Health Coverage:

Other Health Coverage: Insurance #:

Is your child currently attending OCDC, WICAP, Preschool Promise, or any other Head Start program? ☐ Yes ☐ No

Was your child referred to the program by an agency? ☐ Yes ☐ No If yes, check all that apply:

☐ Lifeways ☐ DHS ☐ The Family Place ☐ ESD ☐ School District ☐ OHDC ☐ Child Welfare ☐ Other _____

Does your child have any diagnosed disabilities? ☐ Yes ☐ No If yes, check all that apply:

☐ Mental Health ☐ Speech ☐ Hearing ☐ Physical ☐ Other _____

Explanation:

Date of Diagnosis: Source (check one): ☐ Physician ☐ ESD ☐ SOR ☐ Elks

Pregnant moms, please fill out for unborn child

Child's due date

Certification:

I / We have carefully reviewed the information and by signing this application, certify to the best of my knowledge and belief that all information in this application is true and correct.

I / We further understand that this is an application for services that are paid for with federal/state funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature may result in unenrolling my child from Head Start.

Staff Member Printed Name: _____

Staff Member Signature: _____ **Date:** _____

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

For staff use only:

☐ In person interview ☐ Telephone interview