Date stamp received:

The Children's Learning Center
Where every child shines like a star!

650 N.E. A Street, Madras, Oregon 97741
Phone (541)475-3628 Fax (541)475-2583
website: www.madrastclc.org

THIS APPLICATION DOES NOT ENSURE ENROLLMENT. YOU WILL BE NOTIFIED REGARDING THE STATUS OF YOUR APPLICATION AS SOON AS POSSIBLE.

Please mark program desired:

- ☐ **OPK-Head Start** (State funded 3-5 years)
- ☐ **Early Head Start** (State funded 6wks-3 years)
- ☐ **Preschool Program** (Private pay 3-5 years)
- ☐ **Childcare Program** (Private pay 6wks-5 years

Please fill out the application completely and accurately. All information is kept confidential. We are glad to assist you in filling out this application if needed.

How did you hear about our program? _____ Referring Agency: _____

Child Applicant Information (Child applying for services):

First Name	Middle Name	Last Name	Date of Birth	Gender
				☐Male ☐Female

1. Child's Primary language at home: ☐ English ☐ Spanish ☐Other: _____
2. Does child have a documented disability or health impairment? ☐ Yes ☐ No If yes, what type:_____
3. Is child receiving services from High Desert ESD (Early Intervention)? ☐Yes ☐ No *(ROI required for HDESD or provider)*
4. Is their a referral in process with Early Intervention or another community partner? ☐Yes ☐ No *(ROI required for HDESD or provider)*
5. Do you have any concerns for your child's development or do you suspect a disability for you child? ☐Yes ☐ No
6. Does child have any medical conditions that will require classroom accomodation? ☐Yes ☐No

If yes, what type:_____

Family Status: ☐ Two Parent ☐ Single Parent ☐ Foster ☐ Grandparents/Non-Parent ☐ Teen Parent (under 18 years at birth of child)

Primary Parent/Guardian - Living in the home with child applicant:

First Name	Middle Name	Last Name	Date of Birth	Gender
				☐Male ☐Female

Relationship to child: _____ Custody: ☐Yes ☐No ☐Shared ☐Other: _____

Physical Address: _____
Street City State Zip

Mailing Address (if different):_____
Street City State Zip

Phone/Cell: _____ Text Ok? ☐Yes ☐No Email: _____

Secondary Parent/Guardian Information:

First Name	Middle Name	Last Name	Date of Birth	Gender
				☐Male ☐Female

Relationship to child: _____ Custody: ☐Yes ☐No ☐Shared ☐Other: _____

Lives with family: ☐Yes ☐No If no, your address: _____
Street City State Zip

Phone/Cell: _____ Text Ok? ☐Yes ☐No Email: _____

Self-Pay Applicants: Go to #7-signature
Head Start Applicants: Please answer the following questions to the best of your knowledge

To help us determine if your family is eligible for Head Start we must collect proof of income for the relevant time period and other family information. **All information is kept confidential.**

LIST OTHER FAMILY MEMBERS IN YOUR HOUSEHOLD THAT ARE SUPPORTED BY PARENT/GUARDIAN INCOME:

Full Name	Gender	Date of Birth	Relationship to Applicant
	☐Male ☐Female		
	☐Male ☐Female		
	☐Male ☐Female		
	☐Male ☐Female		
	☐Male ☐Female		

1. Is the parent/guardian active U.S. Military/National Guard? ☐Yes ☐No Veteran? ☐Yes ☐No

2. Are you in a single family home of standard conditions and permanent status? ☐Yes ☐No
If the answer is no, please check your current housing situation:

❑ Living with family/friends due to economic hardship	❑ In transitional housing program	❑ In a motel or campground
❑ Migratory children living in any of the above situations	❑ Shelter (Family/Domestic Violence-Safe house)	❑ In a car, park, or public space without water/heat
	❑ Temporary Foster Care Placement	❑ Other:

3. Does any of the following apply to you? ☐Yes ☐No (If Yes, please provide documentation) *(ROI required for DHS)*

❑ TANF (Temporary Assistance to Needy Families)	❑ Foster Care
❑ Families experiencing homelessness	❑ SSI (Supplemental Security Income)

4. If question #3 does not apply, please provide documentation of any the following:

❑ Tax Returns/W2 (Last Calendar Year)	❑ Child Support/Alimony	❑ No Income Statement. Parent/Guardian has not received income in the last 12 months**. (Fill out Statement of No Income provided at school)**
❑ Pay Stubs	❑ Written Statement from Employer or Self-employed **(Fill out Statement Form provided at school)**	
❑ Military Income		
❑ Unemployment Income		

5. What services does your family receive? (Check all that apply):

❑ SNAP (food stamps)	❑ DHS Child Welfare	❑ Mental Health	❑ Subsidized Low Income Housing
❑ ERDC (childcare subsidy)	❑ OHP (Oregon Health Plan)	❑ WIC	❑ Other:

6. Family Circumstances: check all that apply to child's immediate family.

❑ Active case for child abuse/ neglect	❑ Parent/Guardian receiving mental health services	❑ Parent/Child with chronic health or life threatening condition	❑ Child completed Early Head Start
❑ Family affected by domestic violence	❑ Child exposed to substance abuse during pregnancy	❑ Parent/Guardian has child behavioral/mental health concern	❑ Parent/Guardian enrolled in school
❑ Family presently affected by substance abuse	❑ Child in foster care within last 2 years	❑ Death in the immediate family within last 5 years	❑ Parent/Guardian does not have high school diploma/GED
❑ Parent incarcerated/parole/ probation	❑ Child experienced homelessness within last 2 years	❑ Family affected by substance abuse/treatment in last 2 years	❑ Family is non-English speaking
❑ Child receiving mental health services	❑ Child affected by divorce/ separation		❑ Parent/Guardian difficulty reading & writing

If you would like to be considered for Head Start even though you may not otherwise qualify, please describe the special challenges and circumstances of your family. _____

_____

7. I certify that the above information in this application, including financial if included, is to the best of my knowledge, true and correct. I authorize TCLC to access immunization records for my child using the Oregon Alert System.

Parent/Guardian Signature X_____**Date** _____

"This institution is an equal opportunity provider"