

# 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

**Please keep this cover letter for future reference concerning who to call in case of questions or concerns.**

Thank you for your interest in the Head Start / Early Head Start Program. Please complete the enclosed application and return it as soon as possible. You will need to include the following:

\_\_\_\_\_ Completed Application

\_\_\_\_\_ Family income verification, such as your 1040 Tax Statement or pay stubs.

**This application cannot be processed without income verification.**

Upon acceptance into the program a copy of a state issued Birth Certificate **MUST** be provided to Oahe Child Development Center OR an Application for Vital Record Request must be completed. This should be done as soon as possible, but no later than enrollment. You may return these items with your application.

Once your application has been returned and processed, your child will be placed on a waiting list. **During the summer letters are sent out in the middle of June, again at the end of July and then once again at the beginning of August for acceptance in the fall.** If you do not receive an acceptance letter at one of these times, 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 about your application, acceptance or placements of your child on the waitlist or any other concerns call Cindy or Mandy at the Pierre office at 605-224-6603.**

Please return application to:

Cindy Malsam or Amanda Howard  
Oahe Child Development Center  
P.O. Box 907  
Pierre, SD 57501





Oahe Child Development Center  
 Application  
 Early Head Start / Head Start  
 PO Box 907 -2307 E. Capitol Pierre, SD 57501  
 Phone: 605-224-6603 Fax: 605-224-0850

<i>OFFICE USE ONLY</i>	Date Received: _____
Early Head Start: ____	Head Start: ____
ENCODED _____	CB ____ CO ____ HB ____

Please fill out all areas of the application as completely as possible.

Applicant Information (Child or Expectant Woman)			Expectant Woman Due Date:		
First Name Middle Name Last Name			Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Step Mother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Grandparent(s)	Language(s) spoken in the child's home? Primary: _____ Secondary: _____ How well does the applicant speak English? _____		Previously Enrolled in Head Start or Early Head Start: <input type="checkbox"/> Center-Based <input type="checkbox"/> Early Head Start <input type="checkbox"/> Home-Based <input type="checkbox"/> Not Previously Enrolled Date enrolled: _____		
	Race: Primary Adult: _____ (**See Race Key Below) Secondary Adult: _____ Applicant Race: _____		Program name: _____		
Primary Adult			Secondary Adult		
First Name Middle Name Last Name			First Name Middle Name Last Name		
Date of Birth:		Relationship to Child:	Address:		
Telephone Number Information: Home: _____ Work: _____ Cell phone: _____ Message: _____ Daytime phone: _____ E-mail: _____			Date of Birth: _____ Relationship to Child: _____		Telephone Number Information: Home: _____ Work: _____ Cell phone: _____ Message: _____ Daytime phone: _____ E-mail: _____
Primary Adult Employment and Education			Secondary Adult Employment and Education		
Employment: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed Employer Name: _____  Are you attending school/job training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes,Where? _____  Do you belong to any branch 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"/> 10th <input type="checkbox"/> 11th <input type="checkbox"/> HS Graduate <input type="checkbox"/> Some College <input type="checkbox"/> 2 yr college <input type="checkbox"/> Associate's Degree <input type="checkbox"/> BS /BA <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate <input type="checkbox"/> Vocational <input type="checkbox"/> Advanced Other _____			Employment: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed Employer Name: _____  Are you attending school/job training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes,Where? _____  Do you belong to any branch 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"/> 10th <input type="checkbox"/> 11th <input type="checkbox"/> HS Graduate <input type="checkbox"/> Some College <input type="checkbox"/> 2 yr college <input type="checkbox"/> Associate's Degree <input type="checkbox"/> BS /BA <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate <input type="checkbox"/> Vocational <input type="checkbox"/> Advanced Other _____		

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



Health, Nutrition & Developmental Information		
Applicant's Physician/Health Care Provider	Address:	Date of Last Exam:
Name: _____		
Health Care Coverage Information:		
<input type="checkbox"/> CHIP/Medicaid ID # _____ <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Tri-Care ID # _____		
<input type="checkbox"/> Private Health Insurance _____ Policy # _____ <input type="checkbox"/> No Medical Health Coverage		
Applicant's Dentist/Dental Care Provider name:	Address:	Date of Last Exam:
Dental Care Coverage Information:		
<input type="checkbox"/> No Coverage <input type="checkbox"/> CHIP/Medicaid <input type="checkbox"/> Dental Insurance _____ Policy #: _____		
Does the applicant have any health or nutrition related concerns or conditions that the program may need to address? (i.e. asthma, diabetes, failure to thrive, high risk pregnancy, disabling condition or other.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain: _____		
_____		
Does the applicant have any allergies? (foods, medications, seasonal, insect bites) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list and explain if there is a protocol for emergency intervention. _____		
_____		
Does the applicant have any special dietary needs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are they prescribed by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No		
if yes, please explain: _____		
_____		
Does the applicant have any special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No 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)? (i.e. medical, speech therapy, physical therapy, occupational therapy, early childhood special education, counseling, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please describe and provide name and address of service provider _____		
_____		
Provider: _____ Phone: _____ Address: _____		
What is the source of your family's drinking water?		
<input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Rural water <input type="checkbox"/> Bottled water (Does it contain fluoride?): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Lead Screening Assessment. Please check Yes, No or Unsure for each of the following questions:		
1. Does your child live in or regularly visit a house or child care facility that was built before 1950? _____ Yes ___ No ___ Unsure		
2. Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been remodeled (within the last six months)? _____ Yes ___ No ___ Unsure		
3. Does your child have a sibling or playmate that has or did have lead poisoning or is being treated for high lead levels? _____ Yes ___ No ___ Unsure		
4. Does your child come in contact with any adult whose work or hobby involves any of the following: home construction/repair, plumbing/pipe fittings, automotive repair/radiators, battery manufacturing/repair, metal casting/plating/smelting/soldering/welding, furniture refinishing, pottery/stained glass, or industrial machinery or equipment? _____ Yes ___ No ___ Unsure		
5. Has your child ever received blood lead testing and what were the results? _____ Yes ___ No ___ Unsure		
If yes, what were the results _____.		

Parent/Guardian/Expectant Family Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian/Expectant Family Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE READ AND COMPLETE APPROPRIATE SECTION BELOW**  
**ONLY IF APPLYING FOR PIERRE HEAD START CENTER**

**Please complete this section ONLY if you are agreeing to be responsible for your child's transportation to and/or from the Pierre Center.**

<b>Self Transportation Agreement</b>	
<p>I, _____, agree to the following concerning my child, _____ (parent/guardian) (child name)</p> <p>I will be responsible for my child's transportation to and/or from the Pierre Center. I understand that Head Start Performance Standards require attendance to be maintained at or above 85% and will uphold this to the best of my ability.</p> <p>_____ (parent/guardian signature) _____ (date)</p>	

**Please mark YES only if you CANNOT self transport.**

<b>Transportation Services</b>		
<p>Transportation Services will be provided to families with the greatest need. If you would like to apply for transportation services, please request a <u>Transportation Application/Needs Assessment</u>.</p> <p>Please note that only a limited number will be eligible for this benefit.</p>		
<input type="checkbox"/> Yes, I would like to fill out a Transportation Needs Assessment. <i>(I understand that the information provided in the assessment MUST be verifiable and documented.)</i>	<input type="checkbox"/> NO-I will be transporting my child.	<input type="checkbox"/> I will be willing to help with transportation needs. (Car-Pooling)