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. If you have any questions about this application, or need any help in completing it, please call us for assitance we will be glad to help!

Child Name: _____ **Date of birth:** _____ ☐ Male ☐ Female
First Name Middle Last Name

Race (Check all that apply): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐Other: _____

Ethnicity (Mark one): ☐ Hispanic or Latino Origin ☐Non-Hispanic or Latino Origin

Primary language at home: ☐ Spanish ☐ English Other: _____

Does child have a documented disability or health impairment? ☐ Yes ☐ No If yes, what type:_____

Is child receiving services from ESD (Early Intervention): ☐Yes ☐ No

Does child have any medical conditions that will require classroom accomodation? ☐Yes ☐No

If yes, what type:_____

Child's Doctor _____ Child's Dentist _____
Name Location/Office Name Location/Office

Family Living Address: _____
Street City State Zip

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

Check one: ☐ Two Parent Family ☐ Single Parent Family ☐ Foster Family ☐ Grandparents ☐ other: _____

Adult 1: _____ DOB: _____ Relationship to child: _____
First Name Middle Last Name

Custody: ☐Yes ☐No Lives with family: ☐Yes ☐No Language/s:_____

Phone number: _____ Work: _____ Email: _____

Adult 2: _____ DOB: _____ Relationship to child: _____
First Name Middle Last Name

Custody: ☐Yes ☐No Lives with family: ☐Yes ☐No Language/s:_____

Phone number: _____ Work: _____ Email: _____

Preschool/Childcare applicants: Answer "How did you hear about our program" & Sign below
Head Start Applicants: Complete the application & Sign below

Is this application for a Foster Child? ☐Yes ☐No **Does anyone in your household receive SSI?** ☐Yes ☐No
Is your family currently receiving TANF benefits (Cash)? ☐Yes ☐No **Do you have permanent housing?** ☐Yes ☐No
If not, please describe your current housing situation: _____

_____

Family Size- List all other people living in your household that are supported by your income:

	Name	Relationship to child	Date of Birth
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Adult 1: Highest grade completed: ☐ Masters ☐ BA Degree ☐ AA Degree ☐ GED or HS Diploma ☐ 9 or less ☐Other_____
Employment status: ☐At home by choice ☐ Full-time ☐ Part-time ☐ Retired/Disabled ☐Training/School ☐ Unemployed ☐ Military ☐Seasonal

Adult 2: Highest grade completed: ☐ Masters ☐ BA Degree ☐ AA Degree ☐ GED or HS Diploma ☐ 9 or less ☐Other_____
Employment status: ☐At home by choice ☐ Full-time ☐ Part-time ☐ Retired/Disabled ☐Training/School ☐ Unemployed ☐ Military ☐Seasonal

To help us determine if your family is eligible for Head Start, we need to know your gross income. Please include income documentation that best reflects your current income situation. Federal guidelines require that all income be verified at the time of enrollment.
☐ Pay Stubs ☐ Tax Returns 1040 ☐ Unemployment Insurance ☐ Written Statement from Employer ☐ W-2 Forms ☐ SSI Benefits
☐ Child Support Information ☐ TANF Cash assistance ☐ Foster Documentation ☐ Other: _____

Is your family being served by another agency? (Please check all that apply): ☐ SNAP ☐ Oregon Health Plan ☐ DHS
☐ ERDC ☐ Bestcare Services ☐ Low Income Housing ☐ WIC ID #: _____ ☐Other: _____

Family circumstances which have occurred in the last year:
☐ Child Abuse or neglect ☐ Mental health services ☐ Divorce ☐ Serious Family Health Problem ☐ Domestic Violence ☐ Drug or Alcohol Abuse
☐ Parent Presently in Jail ☐ Parent/guardian active military ☐ Referred by a child welfare agency: _____

Other Comments/Special Circumstances: 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. _____

_____

How did you hear about our program?

☐Returning Family ☐Family/Friends ☐Website ☐Flyer ☐Fair ☐WIC ☐Health Department ☐Doctor ☐DHS ☐Week of the Young Child ☐Bestcare ☐Early Intervention ☐Juniper Junction Relief Nursery ☐Other: _____

I have read this application form and understand it. I certify that the above information, including financial if included, is to the best of my knowledge, true and complete. X_____
Parent/Guardian Signature **Date**

TCLC has permission to access immunization records using the Oregon Alert System. X_____
Parent/Guardian Signature **Date**

Head Start: I authorize TCLC to verify my family income and circumstances with the Oregon Department of Human Services (DHS), with my employer, and by contacting third parties, if necessary. X_____
Parent/Guardian Signature **Date**

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."