

OESD 114 Early Head Start / Head Start / ECEAP Program Inquiry Form

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Applicant (Child)						
First (legal)	Middle	Last (legal)	Suffix	Nickname	Birthday	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Adult (or Prenatal Applicant)						
First (legal)	Middle	Last (legal)	Suffix	Birthday	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Prenatal <input type="checkbox"/> Yes Approximate Due Date: _____
Relationship to child:				Interpreter Needed: If yes, what language?		
Family Size: How many people live in your household?						

Family Contact Information			
Email Address (required):			
Living Address	Address (include any apt. number)	City	Zip
Family Mailing Address			
Same as living? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mailing Address (if different)	City	Zip
Phone Number(s)	Type (<i>check one</i>)	Opt In for Text Messages	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Child/Family Information:		
Child has an IEP/IFSP: <input type="checkbox"/> Yes <input type="checkbox"/> No	Concerns about child's development: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gross Annual Household Income:
How did you hear about the program?		
Additional Information:		