



Ottawa County Early Childhood Application 2020-2021

(Please use this application to apply or receive information for early childhood programming in Ottawa County)

To apply online go to hmgOttawa.org and click

Contact Us

CHILD INFORMATION

Application Date _____

Child's Legal Last Name	Child's First Name	M.I.	Nickname	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Birthday (month, day, year)	My child is transitioning from Early Head Start <input type="checkbox"/> YES <input type="checkbox"/> NO		My child is transitioning from Early On <input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you or your doctor have concerns about your child's development? (i.e. language, motor, behavior) <input type="checkbox"/> YES (Please explain) <input type="checkbox"/> NO				
Does your child have a current IEP or IFSP? <input type="checkbox"/> YES <input type="checkbox"/> NO				

HOUSEHOLD INFORMATION

ADDRESS			
Living Address: Street / Apartment	City / State / Zip	County	Phone Number
Mailing Address (if different): Street / Apartment	City / State / Zip	County	Phone Number
Which school district do you live in? (circle one) Allendale Coopersville Grand Haven Hamilton Holland Hudsonville Jenison Saugatuck Spring Lake West Ottawa Zeeland			
How many times have you moved in the last year?	Do you have a permanent residence? <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you been homeless in the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Email Address: _____		I am interested in receiving Early Childhood information by <input type="checkbox"/> email <input type="checkbox"/> text <input type="checkbox"/> both <input type="checkbox"/> neither	

HOUSEHOLD- PLEASE LIST ALL MEMBERS

							Circle One			
Last Name	First Name	M.I.	Date of Birth	Relationship to Child	Sex <input type="checkbox"/> M <input type="checkbox"/> F	High School Grad	Non-Grad	GED	Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Total # in household: _____

Previous 12 months of income: \$ _____

List any parent(s) not living in above household: Name _____ Relationship to child: _____

VERIFICATION OF 12 MONTHS OF INCOME MUST BE ATTACHED IN ORDER TO PROCESS YOUR APPLICATION

A copy of your 2019 Tax Return, W2's, verification of Child Support, Unemployment and/or Disability Income

Check box if family is receiving any of the following services:

MDHS Child Care Reimbursements SSI FIP Payments Work First Child is a Foster Child

Name	Amount: \$ <input type="checkbox"/> yearly <input type="checkbox"/> monthly <input type="checkbox"/> weekly	Description
Name	Amount: \$ <input type="checkbox"/> yearly <input type="checkbox"/> monthly <input type="checkbox"/> weekly	Description

TRANSPORTATION INFORMATION (if available)

Pick Up Location <input type="checkbox"/> Home <input type="checkbox"/> Childcare	If Childcare, Name:	Address	Phone
Drop Off Location <input type="checkbox"/> Home <input type="checkbox"/> Childcare	If Childcare, Name	Address	Phone
Are you able to self-transport? <input type="checkbox"/> YES <input type="checkbox"/> NO			

PARENT INFORMATION

Are parents able to speak English? <input type="checkbox"/> YES <input type="checkbox"/> NO	Primary language spoken in home	Secondary language spoken in home			
Does either parent have a disability? <input type="checkbox"/> YES _____ <input type="checkbox"/> NO	Is either parent on Active Military Duty? <input type="checkbox"/> YES _____ <input type="checkbox"/> NO	Is either parent incarcerated? <input type="checkbox"/> YES _____ <input type="checkbox"/> NO			
Has child lost a parent or sibling due to death? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has child been abused/CPS involved? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have a chronically ill family member? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you a recent immigrant/refugee? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have a current/history of domestic violence? <input type="checkbox"/> YES <input type="checkbox"/> NO	Substance abuse/addiction? <input type="checkbox"/> YES <input type="checkbox"/> NO
How did you hear about this program?					

IF I CANNOT BE REACHED, PLEASE CONTACT:

Name	Phone Number	Relationship to child
Address		City / State / Zip

I hereby release this information to be shared by Help Me Grow-Ottawa, Ottawa Area Intermediate School District, Child Development Services - Lakeshore Head Start and any location preference indicated below.
 Additionally, if I do not qualify for tuition free preschool programs, I give the Ottawa Area Intermediate School District permission to give my application to tuition assistance programs (Ready for School) **Yes No**

NOTE: APPLICATION MUST BE SIGNED IN ORDER TO BE PROCESSED

Signature of Parent/Guardian: _____

Date: _____

Check all options for which you are interested in applying:

- Home-Based Services
(Parents as Teachers/ Early Head Start)
- Childcare
- Three Year Old Preschool
Location preference _____
- Four Year Old Preschool
Location preference _____
- Other _____

See Early Childhood Program Options and Income Guidelines to help in making your choice at hmgOttawa.org.

If this is an agency referral please fill out the following:

Contact Person: _____

Agency: _____

Phone/Email: _____

Please return application to:**CDS Lakeshore Head Start**

Attn: Amanda McCreight
 100 South Pine St. Suite 220
 Zeeland, MI 49464

or amccreight@cdsoc.org**For Questions:**

616-786-0736

Office use only:

Type of interview: PHONE IN PERSON Who did you speak with? _____

Verify family/household information (i.e. is this everyone living in the household?) _____

Is proof of income attached that is appropriate to the family situation? Yes No

Staff Signature _____ date: _____

***Filling out this application does not guarantee acceptance in programs.**