



**Community Day School
Association**

Discovering and Cultivating the Best in Each Child

**Preschool
Enrollment Packet
2010-2011**



Community Day School Association

**Enrollment Application
2010-2011**

Center Name: _____

CHILD INFORMATION

_____ New Student _____ Returning Student

Child: First _____ Last _____ Birth Date ____/____/____ Age _____
School and Room # _____ Teacher _____ Bus # _____ Pick up/Drop
off location _____ a.m. pick up time _____ p.m. pick up time _____ **Requested start date** _____

PAREN/GUARDIAN INFORMATION

1. Parent/Guardian _____ Relationship _____

Address _____ Zip Code _____

Employer _____ Occupation _____ E-mail _____

↑*Please check here if you agree to receiving your monthly invoice by email at the address given above

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

2. Parent/Guardian _____ Relationship _____

Address _____ Zip Code _____

Employer _____ Occupation _____ E-mail _____

↑* Please check here is you agree to receive your monthly invoice by email at the address given above

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

Family Living Together / Apart (*please circle*) Child's Main Residence _____

Sibling(s) and their age(s) _____

Emergency Contacts

First _____ Last _____ Relationship _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

First _____ Last _____ Relationship _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

First _____ Last _____ Relationship _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

In case of emergency and I cannot be contacted, I hereby give permission for my child to be given emergency treatment by a qualified staff member at Community Day School Association, to be transported by ambulance or aid car to an emergency center, and/or to receive whatever medical, surgical, and hospital care, treatment, and procedures are deemed immediately necessary by the attending physician to safeguard my child's health.

Signature _____ Date _____



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Out of Area Contact (i.e. natural disaster)

First _____ Last _____ Relationship _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

AUTHORIZED ESCORTS (Person's authorized to pick up your child from CDSA)

1. Name _____ Last _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

2. Name _____ Last _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

3. Name _____ Last _____

Home phone (____) _____ Work phone (____) _____ Cell phone (____) _____

Is there anyone CDSA should be aware of who has a legal restraining order prohibiting or limiting contact with your child? **YES NO** (please circle) **If YES, please list his/her name and attach the required legal document to this form.**

Name _____ Relationship to child _____

Any custody or visiting arrangements CDSA needs to be aware of? _____

How did you hear about CDSA? Thank you for helping us to better target our marketing efforts

- _____ Flier mailed to my home
- _____ Flier came home with my child, from Seattle Public Schools
- _____ Roadside Banner or Lawn Sign
- _____ Internet/Web Site
- _____ CDSA Employee _____
- _____ CDSA Parent _____
- _____ Other _____



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EMERGENCY/HEALTH INFORMATION FORM

Physician: Name: _____ Phone(____) _____

Address: _____

Dentist: Name: _____ Phone (____) _____

Address: _____

Name of Insurance Policy _____ Policy# _____

Food or Drug Allergies _____

What additional information should CDSA be aware of if your child comes in contact with the allergen? _____

Date of last complete health exam ____ / ____ / ____ Date of last Tetanus shot ____ / ____ / ____

Date of last Dental exam ____ / ____ / ____

Please describe any specific health or emotional problems (*vision, hearing loss, diabetes, etc.*) or pertinent family background information which CDSA should be aware of (*use back if necessary*)

Community Day School Association (CDSA) requires all medications taken by the child to be listed below:

Please indicate below if your child has any of the following medical conditions:

- _____ Asthma
- _____ Diabetes
- _____ Eczema
- _____ Epilepsy
- _____ Fainting Spells
- _____ Frequent colds
- _____ Frequent ear infections
- _____ Frequent sore throats
- _____ Frequent nosebleeds
- _____ Heart concerns



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- _____ Problems with diarrhea
- _____ Problems with constipation
- _____ Stomach upsets
- _____ Urinary problems
- _____ Other _____

EMOTIONALLY SAFE AND HEALTHY LEARNING ENVIRONMENT

Community Day School strives to ensure that our children are emotionally and physically healthy. To ensure a healthy and safe environment, we request that you provide us with any information regarding any current or previous behavior challenges that your child may have had or has. Based on the professional levels of our employees, we will provide the best possible care for your child.

1. Does your child have disabilities or any health concerns that will affect his or her ability to participate in activities?
If yes, please explain.

2. Has your child ever been suspended from school? _____ No _____ Yes Date ____/____/____
If yes, please explain.

3. Is or has your child ever been on an Individual Education Plan (IEP)? _____ No _____ Yes
If yes, please explain (please include specific dates of initial IEP and/or upcoming reviews, etc)

I hereby certify that all the information is true and accurate.

Signature _____ Date ____/____/____



Community Day School Association

The staff members of Community Day School Association are dedicated to insuring that your child's needs are served to the fullest of our abilities. We feel that it is important that we have as much information about your child as possible to enable us to meet this goal.

Please help us get to know your child, as well as your needs and expectations from our program by completing the following questionnaire. Thank you.

Parent's Name First _____ Last _____

Child's Name First _____ Last _____

1. Does your child have a nick name he/she prefers?
2. Please describe some of your child's favorite activities.
3. Please describe some activities that your child does not enjoy.
4. What are your child's favorite foods? Least favorites?
5. When your child is angry or upset, what kind of behaviors are they likely to exhibit?
6. At CDSA we are pleased to have many different types of families represented in our program population. Please describe your family to us, (i.e. ethnic background, family living situation, siblings and relatives in the household, etc.)
7. Have there been recent family changes?
8. What activities would you like to see your child doing at CDSA?
9. What expectations do you have of the program?



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10. CDSA is dedicated to offering programs that are of interest and benefit to parents and families as well as to children. Please rate the following topics in order of their importance and relevance to you.

- _____ Parenting Skills
- _____ Anger and Stress Management
- _____ Self-Esteem
- _____ Conflict Resolution
- _____ Adolescence and Growing up issues
- _____ Other

11. Is your family in need of resources? _____ No _____ Yes (check all that apply)

- _____ Clothing
- _____ Counseling
- _____ Food
- _____ Health/Medical
- _____ Lodging/Shelter
- _____ Other

12. CDSA invites you and your family to get involved in our program. Please share ways in which you are willing and able to become involved:

- _____ Classroom/Fieldtrips
- _____ Donations
- _____ Tutoring
- _____ Volunteering
- _____ Administrative
- _____ Events



**Community Day School Association
2010-2011 Preschool Tuition Agreement**

Parent's Name _____

Child's Name _____ Center _____

*Please initial each agreement and sign at the bottom.
Return original to the Center Director and keep one copy for your files.*

Initial

_____ 1. An annual registration fee of \$50 per child is payable at the time of registration and is non-refundable.

_____ Paid _____ Included

_____ 2. My base tuition is \$ _____ per month, payable **IN ADVANCE**. 10% sibling discount applies to base tuition only. **Preschool tuition** is based on a 12-month year and **100% tuition will be charged year round**.

_____ 3. *(For subsidized families)* My copayment amount is determined by the funding organization and is subject to change. I understand that I am responsible for payment of care not covered by the funding source and my copayment for care is payable in advance. My funding organization is (circle one) DSHS City of Seattle

_____ 4. *(For subsidized families)* **Written proof of coverage is required before care can begin. If proof cannot be obtained prior to enrollment, you must pay in advance for your child's care.** You must be allocated full-time hours from your subsidy organization to get full time care during school breaks, in-service days, and other school closures. If you are only allocated half-time care, your child may only attend for half a day. **For city subsidy families**, additional fees will be charged for full day care during school breaks, in-service days, and other school closures.

_____ 5. *(For subsidized families)* DSHS - Absences may not exceed five (5) per month.
City - Absences may not exceed ten (10) per month. Children with excessive absences will be asked to leave the program.

_____ 6. My child will attend CDSA: 5 days ONLY

7 a.m.-3 p.m.	MON	TUE	WED	THU	FRI
7 a.m.-6 p.m.	MON	TUE	WED	THU	FRI
9 a.m.-3 p.m.	MON	TUE	WED	THU	FRI
9 a.m.-6 p.m.	MON	TUE	WED	THU	FRI

_____ 7. CDSA provides optional care on in-service days, early dismissal, and other school closure days. Optional care is not part of your regular schedule and is provided at an additional fee to be paid in advance of the care. Drop in care is also available at an additional fee. *(See page 13 of the Parent Information Guide for details)*

_____ 8. Refunds are not given for sick days, snow days, natural disasters or other unscheduled absences.

_____ 9. I agree that should I need to make a schedule change or cancel childcare needs that I submit a **Schedule Change Form no later than the 20th of the month preceding the change** and I agree that tuition will not be refunded within the month following the date notification of a change was made.

_____ 10. Child(ren) must be picked up by 6 p.m. Beginning at 6:01 p.m., a \$5.00 late charge will be assessed for the first five minutes and then \$1.00 for every minute thereafter payable to CDSA the same day.

Signature _____ Date _____



**Community Day School Association
2010-2011 Preschool Parent Agreement**

Parent's Name _____

Child's Name _____ Center _____

Please initial each agreement and sign at the bottom. Return original to the Center Director with the emergency form, tuition agreement, immunization form, biographical information form, food program form, and United Way client demographic form.

Initial

_____ 1. I grant permission for CDSA to provide care to my child including use of play equipment and supplies, involvement in all activities and participation in fieldtrips.

_____ 2. I have provided CDSA with the following information on the emergency form:

- _____ **Parent/Guardian name, address, home, cell and work phone numbers**
- _____ **Emergency contacts**
- _____ **Physician name and phone number**
- _____ **Food or drug allergies, asthma, disabilities, any chronic medical need, etc.**
- _____ **Persons authorized to pick up your child from CDSA plus phone numbers**
- _____ **Any additional relevant information**

_____ 3. I understand that CDSA is not responsible for personal items brought from home that may be lost.

_____ 4. I give permission for my child to be included in photographs taken at CDSA. I understand that photographs of my child may be used in our publications, including our website and marketing materials. I am able to withdraw my permission at any time for my child's photograph to be used in CDSA publications and will notify my Center Director in writing.

_____ 5. I have read and understand the Family Information Guide and am aware that CDSA reserves the right to decline enrollment for any of the following reasons:

- a. CDSA Conflict-Resolution Policy (*See page 20 of the Family Information Guide for details*)
- b. Non-payment of tuition/co-payment by due date
- c. Non-payment of tuition because subsidy has been denied or expired
- d. Physical or emotional problems that are beyond reasonable accommodations
- e. Parent/Guardian failure to comply with CDSA's policies and procedures

_____ 6. I have included on the emergency form all information that could significantly affect my child's ability to work with staff and other children. I will notify CDSA of any address and phone number changes.

_____ 7. CDSA is not responsible for anything that may happen as a result of incomplete information given by a parent/guardian on the emergency form or other documentation at the time of enrollment.

_____ 8. Children with the mental & physical capacity to apply sun screen will self apply under the supervision of CDSA staff. If the child is unable to do so, a CDSA staff member will apply as needed.

_____ 9. I agree to send a nutritionally balanced lunch with my child (ren) daily.
CDSA is required by law to monitor the nutritional content of food that is consumed during meals and snacks while in our care.

_____ 10. I understand that I have access to view the center's Disaster Plan, Pesticide and Health Care Policy.

_____ 11. I give permission for my child to participate in walking field trip in the neighborhood. I understand that will occur without written permission.

_____ 12. I give my permission to have my child participate in one health screening and three developmental screenings during the school year. I also understand that if my child is identified to have learning difficulties that an intervention plan will be developed and implemented in partnership between myself and the teachers.
More on Back.....

_____ 13. In understanding the importance of the learning that happens when children attend preschool consistently, I commit to ensuring that my child attends preschool 85% of the time during the school year (this does not include excused absences: illness, family emergency, religious observances or practices, and culturally relevant family activities).

_____ 14. I have read and understand the Child of Concern Policy

Signature: _____ Date: _____

Child and Adult Care Food Program ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 - CHILDREN'S INFORMATION

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care						Circle Meals Normally Received		
			Sun	Mon	Tu	Wed	Th	Fri	Sat	Breakfast	A.M. Snack
			Normal Hours _____ to _____						P.M. Snack	Supper	Eve. Snack
			Normal Hours _____ to _____						Breakfast	A.M. Snack	Lunch
			Normal Hours _____ to _____						P.M. Snack	Supper	Eve. Snack
			Normal Hours _____ to _____						Breakfast	A.M. Snack	Lunch
			Normal Hours _____ to _____						P.M. Snack	Supper	Eve. Snack

INCOME ELIGIBILITY

Please check one box:

- My child(ren) receive(s) benefits from Washington Basic Food (WBF), TANF, or FDPIR. (Please complete Part 2 and 5.)
- This child is a foster child. (Please complete Part 3 and 5.) One form per foster child.
- My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 - CHILDREN RECEIVING WASHINGTON BASIC FOOD (WBF), TANF, OR FDPIR

Child's Name	Circle One			Case Number or Identification Number
	WBF	TANF	FDPIR	

PART 3 - FOSTER CHILD—One form per foster child

Child's Name	Child's Personal Use Monthly Income (if None, Write "0")

PART 4 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not Required if You Have Reported a Case Number in Part 2

List Names (First and Last) of Everyone in Your Household	Gross Income from Last Month (if None, Write "0")			
	Earnings from Work Before Deductions	Alimony, Child Support, etc.	Retirement, Pensions, Soc. Sec., etc.	Job Two or Any Other Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PART 5 - SIGNATURE AND CERTIFICATION

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) If you have listed a case number in Part 2 or are applying for a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, a Social Security number is not needed.

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing	<input type="checkbox"/> I do not have a Social Security Number
		Social Security Number	
ADDRESS		CITY/STATE/ZIP CODE	DAYTIME PHONE

PART 6 – IDENTIFYING INFORMATION AND CERTIFICATION OF DATA—You Are Not Required to Answer This Part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, gender, age, or disability.

Race:

- White
- Black or African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Pacific Islander
- Multi-Racial

If you feel you have been discriminated against, you should write the Secretary of Agriculture, Washington, DC 20250.

PRIVACY ACT STATEMENT

Section 9 of the National School Lunch Act requires that, unless the participant's WBF, TANF, or FDPIR case number is provided, you must include the social security number of the adult household member signing the application, or indicate that the household member does not have a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the signer does not have a social security number, the application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a WBF or welfare office to determine current certification for receipt of WBF or TANF benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY

Check one: Free Category WEEKLY X 4.33 MONTHLY INCOME CONVERSION
 Reduced-Price Category EVERY 2 WEEKS X 2.15 TWICE A MONTH X 2
 Above-Scale Category Total Monthly Income \$ _____

This form must be signed and dated by the institution's authorized representative.

SIGNATURE OF INSTITUTION'S AUTHORIZED REPRESENTATIVE

DATE

2009 - 2010 HUD Income Categories

Instructions: Find the column for the number of people in your household. Go down that column until you find the income range for your annual gross income last year. Look to the left to see what that row is labeled. That is your Income category.

Household → ↓ Category	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
<u>Category A.</u> Very Low. 30% HUD PMSA	Up to \$17,700	Up to \$20,250	Up to \$22,750	Up to \$25,300	Up to \$27,300	Up to \$29,350	Up to \$31,350	Up to \$33,400
<u>Category B.</u> Low. 50% HUD PMSA	\$17,701 to \$29,500	\$20,251 to \$33,700	\$22,751 to \$37,950	\$25,301 to \$42,150	\$27,301 to \$45,500	\$29,351 to \$48,900	\$31,351 to \$52,250	\$33,401 to \$55,650
<u>Category C.</u> Moderate. 80% HUD PMSA	\$29,501 to \$44,800	\$33,701 to \$51,200	\$37,951 to \$57,600	\$42,151 to \$64,000	\$45,501 to \$69,100	\$48,901 to \$74,250	\$52,251 to \$79,350	\$55,651 to \$84,500
<u>Category D.</u> Above Moderate. Above 80% HUD PMSA	\$44,801 or More	\$51,201 or More	\$57,601 or More	\$64,001 or More	\$69,101 or More	\$74,251 or More	\$79,351 or More	\$84,501 or More

Note:

- FY 2009, Washington State Median 4-Person Family Income = \$84,300
- HUD (U.S. Department of Housing & Urban Development)
- PMSA (Primary Metropolitan Statistical Areas)

Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

- Diphtheria Hepatitis A Hepatitis B Hib Measles Mumps Polio Rubella Tetanus Varicella
 Other (list): _____ lab report(s) attached (required)

X

Typed or Printed Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X

Signature of Licensed Health Care Provider (required)

Date (required)

Vaccine Trade Names*

Read down and across - Trade Names are in Alphabetical Order.

Trade Name	Vaccine	Trade Name	Vaccine
Acel-Imune	DTaP	Menomune	MPSV4
ActHIB	Hib	OmniHIB	Hib
Adacel	Tdap	Pediarix	DTaP + IPV + Hep B
Boostrix	Tdap	PedvaxHIB	Hib
Certiva	HPV	Pentacel	DTaP + IPV + Hib
Comvax	Hib + Hep B	Pentavalente	DTaP + Hep B + Hib
Daptacel	DTaP	Pneumovax	PPV23
Decavac	Td	Prevnar	PCV or PCV7
Engerix-B	Hep B	ProHIBIT	Hib
Fluarix	Flu	ProQuad	MMRV
FluMist	Flu	Quadracel	DTaP + IPV
Fluvirin	Flu	Recombivax	Hep B
Fluzone	Flu	Rotarix	Rotavirus
Gardasil	HPV	RotaTeq	Rotavirus
Havrix	Hep A	Tetramune	DTP + Hib
HibTITER	Hib	TriHIBit	DTaP + Hib
HyperTET	TIG	Tri-Immunol	DTP
HyperHEP B	HBIG	Tripedia	DTaP
Ipol	IPV	Twinrix	Hep B + Hep A
Infanrix	DTaP	Vaqta	Hep A
Kinrix	DTaP + IPV	Varivax	Varicella
Menactra	MCV4		

Vaccine Abbreviations*

Read down - Abbreviations are in Alphabetical Order.

Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus
DTaP	Diphtheria, Tetanus, acellular Pertussis
DTP	Diphtheria, Tetanus, Pertussis
Flu (TIV or LAIV)	Influenza
HBIG	Hepatitis B Immune Globulin
Hep A (HAV)	Hepatitis A
Hep B (HBV)	Hepatitis B
Hib	Haemophilus influenzae type b
HPV	Human Papillomavirus
IPV	Inactivated Poliovirus Vaccine
MCV4	Meningococcal Conjugate Vaccine
MPSV4	Meningococcal Polysaccharide Vaccine
MMR	Measles, Mumps, Rubella
MMRV	Measles, Mumps, Rubella, Varicella
OPV	Oral Poliovirus vaccine
PCV or PCV7	Pneumococcal Conjugate Vaccine
PPV23	Pneumococcal Polysaccharide Vaccine
Rota (RV1 or RV5)	Rotavirus
Td	Tetanus, Diphtheria
Tdap	Tetanus, Diphtheria, acellular Pertussis
TIG	Tetanus immune globulin
VAR or VZV	Varicella

*These lists may not be comprehensive; visit <http://www.doh.wa.gov/cfh/immunize/forms/default.htm> for updated lists.

Standardized Client Demographic Data Collection Form for use 01 July 2010 through 30 June 2011

Agency	Community Day School Association	0000012243
Outcome	Youth/children develop/strengthen skills/competencies/assets that support positive development	02204

Client Instructions: Please neatly enter numbers or make an X in the appropriate boxes to answer the questions. Please note your name is not a part of this survey so that your identity is totally confidential.

I. Geographic Region:

1. What is the Zip Code where you live:

--	--	--	--	--

Homeless – formerly from ZIP and/or City

2. City Name _____
(if not in a city, write in "Unincorporated")

Unknown

II. Household Composition

1. Number of people living in your household
(including yourself)

--	--

Unknown

2. Number of children under 18

--	--

Unknown

3. If you are in a single parent household, is the head of the household male or female?

Male (1)

Female (2)

Unknown (9)

III. Household Income Level

1. What is the total gross yearly income for your household, based on King County HUD guidelines?

Under 30% of Median Income (1)

Under 50% of Median Income (2)

Under 80% of Median Income (3)

Equal or Above 80% of Median Income (4)

Unknown (9)

IV. Living Situation

1. Are you Homeless?

Yes (1)

No (0)

Unknown (9)

If homeless "Yes",

2. How many times have you been homeless in the past three years?

Number of times

--	--

 Unknown

3. How long have you been homeless this last time?

Number of months

--	--

 Unknown

V. Age Group

1. What is your child's age at intake?

Number of Years

--	--	--

Age Unknown

VI. Gender

1. Please check one of the following

Female (1)

Male (2)

Transgendered (3)

Other (4)

Unknown (9)

VII. Persons with Disabilities

1. Do you consider yourself to be a person with a disability?

Yes (1)

No (0)

Unknown (9)

(Continued on Page 2)

VIII. Spanish/Hispanic/Latino

1. Are you Spanish/Hispanic/Latino?
 Yes (1)
 No (0)
 Unknown (9)

IX. Race

1. What is your race? (Check all that apply)

- a.**
 American Indian (U.S. Tribe)
 Alaska Native, Aleut, Eskimo
 Indigenous to Americas (Other than U.S.)
- b.**
 Asian Indian
 Cambodian
 Chinese, Except Taiwanese
 Filipino
 Japanese
 Korean
 Vietnamese
 Other Asian
- c.**
 Indigenous African/Black
 African American/Black
 Other Black
- d.**
 Hawaiian Native
 Polynesian (Samoan, Tongan, Other)
 Micronesian (Guamanian/Chamorro, Other)
 Other Pacific Islander
- e.**
 Arab/Iranian or Middle Eastern
 Other White/Caucasian
- f.**
 Other
- G.**
 Unknown

X. Refugee/Immigrant

1. Are you an immigrant or refugee or new arrival to this country?
 Yes (1)
 No (0)
 Unknown (9)

XI. Limited English Proficiency

1. Are you limited in your ability to communicate in English?
 Yes (1)
 No (0)
 Unknown (9)

XII. Employment Status at Intake

1. Are you currently employed?
 Yes (1)
 No (0)
 Unknown (9)

XIII. Educational Level Adults (for adults only)

1. What is the highest grade or degree that you have achieved?
- Less than High School graduate (1)
 High School diploma or GED (2)
 Some college—no degree or certificate (3)
 Certificate from business school or other professional program (4)
 Associates Degree (5)
 Bachelors Degree or above (6)
 Child under 18 (7)
 Unknown (9)

XIV. Veterans/Military Status

1. Have you ever served on active duty in the U.S. military (including National Guard or Reserves)
 Yes (1)
 No (0)
 Unknown (9)

Thank you for your cooperation. Individual responses will be kept completely confidential at all times



United Way of King County