

HEAD START





Copy of Medicaid Card

Dear Parents or Legal Guardians:

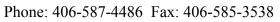
Thank you for your interest in applying to Head Start! Attached you will find application materials. The entire application, PLUS the required information must be complete in order for us to process your child's application. Please refer to the checklist on THIS page to see what is required. Only completed applications can be processed. Head Start is a FREE program. Children with challenges or disabilities welcome!

 INCOME VERIFICATION				
(Please note that all family income must be reported. If your family is receiving TAN benefits or SSI benefits, you will be automatically eligible for Head Start services, By you must still report all income. Foster families are also automatically eligible.)				
Examples of acceptable verification would be:	1040 tax return from prior year			
	Check stubs (past 3 months)			
	W-2 forms			
	Unemployment verification			
	Child Support verification			
	University GRANT verification			
 IMMUNIZATION RECORD				
(If you need assistance in locating this information	on, please contact us!)			
PROOF OF BIRTH				
Acceptable forms of birth proof are:	Hospital copy of birth certificate			
	Certified copy of birth certificate			
	Copy of Passport			

If you have any questions, please call Head Start at 587-4486. The entire staff at Head Start is looking forward to working with your family!

Application for Enrollment

HRDC-Head Start 32 S. Tracy Avenue Bozeman, MT 59715





Child's Name Birth Date			
Living Address			
Mailing Address			
	cific Islander Hispanic Native		
Mother or Legal Guardian		Birth Date	
Living Address			
Mailing Address			
		Work	
Employment: Full time Part time	Unemployed Retired/Disabled	Attends a college or training program	
Race: White Asian Black Pa	cific Islander Hispanic Native	Other:	
Father or Legal Guardian		Birth Date	
Mailing Address			
		Work	
Lives with Child? YES NO	Highest grade completed in school		
Employment: Full time Part time	Unemployed Retired/Disabled	Attends a college or training program	
	cific Islander Hispanic Native	Other:	
Adults: (Please list all adults who ar	re living in this home OTHER than	parents)	
Adult 1:	Relationship to child	Birth Date	
Adult 2:	Relationship to child	Birth Date	
Adult 3:	Relationship to child	Birth Date	
Adult 3:	Relationship to child	Birth Date	

Children: (Please list all OTHE	R children livir	ng in the home. DO NOT inclu	ide the Head Start ch	nild.)
Child 1:		Date of Birth	Sex: Male	Female
Child 2:		Date of Birth	Sex: Male	Female
Child 3:		Date of Birth	Sex: Male	Female
Child 4:		Date of Birth	Sex: Male	Female
Child 5:		Date of Birth	Sex: Male	Female
Child 6:		Date of Birth	Sex: Male	Female
Please mark the classroom you transportation, please keep thi			s no longer able to pr	ovide
Bozeman	Belgrade	Livingston	Gallatin Gatewa	y (AM only)
AM	AM	AM		
PM	PM	PM (if available)		
Are you receiving TANF or S If yes, please provide do Was this child referred to our p	cumentation.	• , ,		
Child's Physician		Child's Dentist		
Does your child have health ins	surance? YI	ES NO Does your child ha	ive dental insurance?	YESNO
If your child is without insurar If no, may we assist you		plied for Medicaid or CHIP? Medicaid or CHIP?YES		
Does your child have a disabili	ty? YES _	NOSuspected If yes, I	Explain	
Does this child have and Indivi	dualized Educa	tion Plan (IEP)?YES	_NO	
Please indicate any of the follow	•	· ·		
		_ Speech/Language Hearing		Developmental
Have you previously been invo If yes, please explain				
Where did you hear about Hea				
Does your child take naps?				
What are your child's strength	s?			
What are your child's challeng	es/concerns?			

Is there any addition	nal information abou	ıt your child that you	ı would like us to knov	w?
		•	e information provided he	• 1
, , , ,		1 6 3	nated. I also understand the	
•		` •	ad Start to receive funding	
Signature			Date	
income-eligible. IF ANY	ONE IN YOUR FAMILY	ur family's income. This in Y RECEIVES TANF OR INCOME STILL NEED	nformation is needed to dete SSI BENEFITS, YOUR C S TO BE VERIFIED.	rmine if your family is HILD IS ELIGIBLE FOR
FAMILY MEMBER	GROSS INCOME (BEFORE TAXES)	HOW OFTEN? (MONTLY, WEEKLY, ETC)	WHERE? (EMPLOYER, TANF, SSI, EDUCATIONAL GRANTS, CHILD SUPPORT, ETC)	EMPLOYMENT STATUS (FULL TIME, PART TIME, UNEMPLOYED, SEASONAL, STUDENT)
PLEASE PRO	VIDE ANY OF THE	FOLLOWING INC	OME DOCUMENTA	ΓΙΟΝ <i>WITH THIS</i>
			FAMILY'S INCOME.	
W-2/TAX RETURI TANF STATEMEN			T <i>GRANT</i> AWARD LET INEMPLOYMENT STAT	
PLEASE COMPI	LETE THIS SECTION	ON IF YOU HAVE N	O CASH INCOME A	T THIS TIME
I verify that I have N following:	O cash income at this	time(plea	ase initial) Please list v	who pays for the
Housing				
Food				
Utilities				
L	PLEA	SE READ AND SIG	N BELOW	
the HRDC Head Start Progr	ram may be terminated. I also		tion I have provided will be sha	of is false, my participation in ared with the Montana
NAME			DATE	

FOR OFFICE USE ONLY.		
TOTAL FAMILY INCOME: \$FOR THE PERIOD OF		
I certify that I have examined the above income documentation and have determined this child income guidelines	is: () income eligible () over the
HEAD START STAFF SIGNATURE:	DATE:	
COMMENTS:		