



HRDC Head Start Application



HRDC
BUILDING A BETTER COMMUNITY

What is HRDC Head Start?

HRDC Head Start (HS) is a Federally funded preschool program for children ages 3 to 5, from low income families. Children attending Head Start participate in a variety of educational activities for half day sessions, Monday-Thursday. They also receive health and development screenings, have healthy meals and snacks, and enjoy playing indoors and outdoors in a safe, secure, social setting. We welcome children with challenges and disabilities!

HRDC Head Start involves families as well as the attending child. Parent support is vital to the success of the program and families are encouraged to volunteer time to the programs. This can include helping in the classroom, preparing activities at home, serving on parent committees, etc. Upon acceptance into a program, your family will receive Family Support services, which include setting goals toward strengthening the family.

How to Apply for An Early Childhood Education Program

Please read this application carefully and fill it out completely. Enrollment is not processed as a first come-first serve basis. Each application contains important information that is used to place your child on the waiting list for the programs if needed. Please provide us with the following information:

- ✓ **General Information:** We must be able to reach you in order to enroll your child. If you move or change your phone number after completing this application, please notify us.
- ✓ **Proof of Birth:** Acceptable forms of proof include birth certificates, passport, or HMK Plus card.
- ✓ **Income:** All family income must be reported. Examples of acceptable proof of income include 1040 tax return, past 3 months of check stubs, W-2 forms, unemployment, child support, university grants, SSI, or TANF.
- ✓ **Immunizations:** Your child must be up-to-date on all age appropriate immunizations and we must have written verification.

***If you need help completing the application or
need help locating any of the following items, please call
us at 406-586-9652.***

What Happens Next?

When we receive your application, we will review it and let you know if we need more information. When an opening becomes available for your child, we will contact you to arrange a time to complete the enrollment process. We will make every effort to accommodate your classroom request.

**Please drop off your application to our office at 33 S. Tracy Ave. or mail your application to
32 South Tracy Bozeman, MT 59715.**

Phone: 406-586-9652 Fax: 406-585-3538

Applications are accepted year round!

HRDC Head Start Application

Please mark the program and classroom you would like your child to attend.

- | | | |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Bozeman HS | <input type="checkbox"/> Belgrade HS | <input type="checkbox"/> Livingston HS |
| <input type="checkbox"/> AM | <input type="checkbox"/> AM | <input type="checkbox"/> 1 |
| <input type="checkbox"/> PM | <input type="checkbox"/> PM | <input type="checkbox"/> 2 |

Child's Name _____ **Birth Date** _____

Gender: MALE FEMALE

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

US Citizen? Yes No Has your child been influenced by a foreign language? Yes No If so, what language? _____

Adult 1 _____ **Birth Date** _____

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

Living Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

E-Mail Address: Please print clearly _____

Lives with Child? YES NO Highest grade completed in school _____

Employment: Full time Part time Unemployed Retired/Disabled Attends a college or training program

Adult 2 _____ **Birth Date** _____

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

Living Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

E-Mail Address: Please print clearly _____

Lives with Child? YES NO Highest grade completed in school _____

Employment: Full time Part time Unemployed Retired/Disabled Attends a college or training program

Other Adult Living in the Home _____ **Birth Date** _____

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

Lives with Child? YES NO Highest grade completed in school _____

Employment: Full time Part time Unemployed Retired/Disabled Attends a college or training program

Please attach a list if you have more than one other adult living in the home.

Children: (Please list all OTHER children living in the home. DO NOT include the attending child.)

Child 1: _____ Date of Birth _____ Gender: Male Female

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

Child 2: _____ Date of Birth _____ Gender: Male Female

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

Child 3: _____ Date of Birth _____ Gender: Male Female

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

Child 4: _____ Date of Birth _____ Gender: Male Female

Race/Ethnicity: White Asian Black Pacific Islander Hispanic Latino Native Other: _____

Please attach a list for additional children living in the home.

Family Information:

What is the parental status in the home? Single Two-parent Foster Grandparent Legal guardian

Are there Custody/Legal Concerns? Yes No

Is there a legal custody document? Yes No

Are there other legal documents? Yes No If Yes, please explain _____

What is the primary language spoken at home? _____

Is your family? Homeless Living in temporary shelter Sharing housing due to loss of housing/economic hardship None

Are you an active military family? Yes No

Are you receiving SNAP/Food Stamps? Yes No

Are you receiving Supplemental Security Income (SSI)? Yes No

Are you receiving TANF? Yes No

Are you receiving WIC? Yes No

Is any individual named on this enrollment form (including parent, guardian, student, sibling, care taker) currently or formerly a registered sex or violent offender? Yes No

Do you receive the Best Beginnings Childcare Scholarship for any child in this household? Yes No

If no, may we offer you more information or assist you in completing a scholarship application? Yes No

Does your child have a diagnosed disability, receive private therapy, or services through the local school district?

Please explain: _____

Speech

Vision

Physical

Hearing

Behavior

PT/OT

Other

Does your child have an IEP? Yes No

Do you have any concerns about your child's development? Please explain: _____

Speech

Vision

Physical

Hearing

Behavior

Other

Medical Information:

Asthma Yes No

Diabetes Yes No

Seizures Yes No

Allergies Yes No

Special Dietary Needs Yes No

Is an EpiPen necessary to control allergic reactions? Yes No

Other: _____

*Additional paperwork will be required for any special conditions to ensure the safety of your child.

Medication Currently taking: At home: _____ At school: _____

Does your child have health insurance? Yes No

Does your child have dental insurance? Yes No

Does everyone in your household have Health Insurance? Yes No

Household Circumstances: (Check all that apply)

Child's parent is incarcerated

Open or previous Child Welfare Services case

Teen Parent

Divorce/Seperation/Marriage

Child is currently experiencing grief/loss

Substance Abuse

Child's parent is disabled

Child's sibling attends/attended Head Start

Domestic Violence

English Language Learner

Returned from Foster placement (last 6 months)

Child Abuse/Neglect

Was Child born prematurely? How many weeks premature? _____

Does your child take naps? Yes No If yes, when? _____

Is your child potty trained? Yes No

Please indicate any of the following services your **family** is receiving: (Check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Family Outreach | <input type="checkbox"/> AWARE | <input type="checkbox"/> Housing Assist. |
| <input type="checkbox"/> Energy Assist. | <input type="checkbox"/> Vision | <input type="checkbox"/> Food Bank | <input type="checkbox"/> Adult Education |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> THRIVE | <input type="checkbox"/> Alcoholics Anon. | <input type="checkbox"/> Substance Abuse |

What are your child's strengths? _____

What are your child's challenges/concerns? _____

Is there anything else you would like us to know about your child/family? _____

How did you learn about our program? _____

Income

Please provide the following information about your family's income. This information is needed to determine if your family is income-eligible. IF ANYONE IN YOUR FAMILY RECEIVES TANF OR SSI BENEFITS, YOUR CHILD IS ELIGIBLE FOR OUR PROGRAM, PLEASE PROVIDE US WITH SSI OR TANF DOCUMENTATION.

PLEASE PROVIDE ANY OF THE FOLLOWING INCOME DOCUMENTATION WITH THIS APPLICATION TO VERIFY YOUR FAMILY'S INCOME.

- | | | |
|---|--|---|
| <input type="checkbox"/> W-2/TAX RETURN | <input type="checkbox"/> CHECK STUBS | <input type="checkbox"/> STUDENT GRANT AWARD LETTER |
| <input type="checkbox"/> TANF STATEMENT | <input type="checkbox"/> SSI STATEMENT | <input type="checkbox"/> UNEMPLOYMENT STATEMENT |
| <input type="checkbox"/> OTHER | <input type="checkbox"/> CHILD SUPPORT FOR PARTICIPATING CHILD | |

PLEASE READ AND SIGN BELOW

I, the parent or legal guardian of the above named child, certify that the information provided here is true. If any part of it is false, my participation in the HRDC Early Childhood Education Program may be terminated. I also understand that the information I have provided will be shared with the Montana Department of Public Health and Human Services, also the Public School District (Necessary for HRDC to continue receiving funding.)

NAME _____ DATE _____

imMTrax Consent Form for Children

Child's Name: _____ Sex: M ___ F ___ Date of Birth: _____

I authorize my health care provider and public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Informational System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Parent/Guardian Signature: _____

Date: _____

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