



A PROGRAM OF HRDC

# 2017-2018 HRDC Head Start Application

**HRDC Head Start** is a Federally funded preschool program for income eligible children ages 3 to 5. Children attending Head Start will engage in foundational learning experiences that will prepare them for school. Our rich play based environments provide a safe, secure, social setting that support the development of all children. Health, developmental screenings and parent teacher conferences, provide opportunity for parents to collaborate with staff for the development of their child. Healthy meals and snacks are part of the education experience.

Parents are the primary educators of their children. We support them as an integral part of our program. Parent involvement in their child's education will start here to form a foundation for involvement throughout their child's school years.

HRDC Head Start supports parents and families in achieving their own goals, parent-child relationships and engaging in community.

## ***How to Apply for An Early Childhood Education Program***

Please read this application carefully and fill it out completely. 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 proof includes birth certificates, passport, or HMK Plus card.
- ✓ **Income:** All family income for the last 12 months or calendar year 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.

## ***Additional Information you will be asked for:***

- ✓ Any custody papers/parenting plans/orders of protection
- ✓ A copy of your child's IEP (Plan for services in school) or IFSP (Plan for services for Family Outreach), if he /she receives services
- ✓ Your child's most recent Well Child Exam Record (Contact your doctor's office to have records faxed)
- ✓ Your child's most recent Dental Exam Record (Contact your dentist's office to have records faxed)

***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?***

As soon as we receive the completed application, including the additional information, we will review it and schedule an appointment either in-person or via phone to verify information on your application. 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 Email: [headstart@thehrdc.org](mailto:headstart@thehrdc.org)

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

Bozeman

AM  PM

Belgrade

Livingston

Child's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Gender:  MALE  FEMALE

Race/Ethnicity:  White  Asian  Black  Pacific Islander  Hispanic /Latino  American Indian Other: \_\_\_\_\_

US Citizen?  Yes  No Has your child been influenced by another language?  Yes  No If so, what language? \_\_\_\_\_

Primary Guardian \_\_\_\_\_ Birth Date \_\_\_\_\_

Race/Ethnicity:  White  Asian  Black  Pacific Islander  Hispanic /Latino  American Indian Other: \_\_\_\_\_

Living Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ \*Cell \_\_\_\_\_ Work \_\_\_\_\_

\*Head Start can text me information at the above cell number  YES  NO

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

Secondary Guardian \_\_\_\_\_ Birth Date \_\_\_\_\_

Race/Ethnicity:  White  Asian  Black  Pacific Islander  Hispanic/Latino  American Indian 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  American Indian 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  American Indian Other: \_\_\_\_\_

Child 2: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female

Race/Ethnicity:  White  Asian  Black  Pacific Islander  Hispanic/Latino  American Indian Other: \_\_\_\_\_

Child 3: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female

Race/Ethnicity:  White  Asian  Black  Pacific Islander  Hispanic /Latino  American Indian Other: \_\_\_\_\_

Child 4: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female

Race/Ethnicity:  White  Asian  Black  Pacific Islander  Hispanic /Latino  American Indian 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

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

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

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

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

Is your child potty trained?  Yes  No If no, Head Start assists with training

**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)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Child's parent is incarcerated                              | <input type="checkbox"/> Open or previous Child Protective Services case | <input type="checkbox"/> Teen Parent         |
| <input type="checkbox"/> Divorce/Separation/Marriage                                 | <input type="checkbox"/> Child is currently experiencing grief/loss      | <input type="checkbox"/> Substance Abuse     |
| <input type="checkbox"/> Child's parent is disabled                                  | <input type="checkbox"/> Child's sibling attends/attended Head Start     | <input type="checkbox"/> Domestic Violence   |
| <input type="checkbox"/> English Language Learner                                    | <input type="checkbox"/> Returned from Foster placement (last 6 months)  | <input type="checkbox"/> Child Abuse/Neglect |
| <input type="checkbox"/> Was Child born prematurely? How many weeks premature? _____ |  |  |

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: \_\_\_\_\_