HRDC ECE is federally funded (Head Start) preschool program for income eligible children ages 3 to 5. Children attending HRDC ECE 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 and developmental screenings along with 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 ECE 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, written document from employer, W-2 forms, SSI payments, unemployment, child support, university grants, SSI, at LEAST three months of pay stubs 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)

**What Happens Next?**

As soon as we receive the completed application, including the additional information, we will review it and contact you to 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 South Tracy Bozeman, MT 59715  
Phone: 406-586-9652  Fax: 406-585-3538  Email: headstart@thehrdc.org
Please mark the program and classroom you would like your child to attend.

- Bozeman
- Belgrade
- Livingston

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<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Race/Ethnicity:</th>
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<td>American Indian</td>
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<tr>
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<td>Other</td>
</tr>
</tbody>
</table>

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Primary Guardian  Birth Date

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

- Primary Language: English
- Spanish
- Other:

- Living Address:  
  City ____________  Zip ____________

- Mailing Address:  
  City ____________  Zip ____________

- Phone Numbers: Home _____________________
  Cell _____________________
  Work _____________________

- E-Mail Address: Please print clearly

Preferred Method of Contact (choose one or multiple):
- Phone Call
- Text Message
- Email

Lives with Child?  Yes  No

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

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Secondary Guardian  Birth Date

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

- Primary Language: English
- Spanish
- 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

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

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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

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

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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 or additional adults living in the home.***
Family Information:
What is the parental status in the home? □ Single □ Two-parent □ Separated Parents □ 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____________________________________________________
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 (check all that apply):
□ SNAP/Food Stamps □ WIC □ Supplemental Social Security(SSI) □ TANF
Is any individual named on this enrollment form (including parent, guardian, student, sibling, caretaker) 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

Do you have any concerns about your child’s development? Please explain: ____________________________________________________________
□ Speech □ Vision □ Physical □ Hearing □ Behavior □ Other

Does your child have a diagnosed disability or receive private therapy?
Please explain: ____________________________________________________________

Does your child have an IEP (Individualized Education Plan) with local school district? □ Yes □ No

Please indicate any of the following services your family is receiving: (Check all that apply)
□ Occupational Therapy □ Family Outreach □ Hearing □ ____________
□ Physical Therapy □ THRIVE □ Vision □ ____________
□ Speech/Language □ AWARE □ YDI □ ____________

Medical Information:
Asthma □ Yes □ No   *If Yes, your child will need a spacer and inhaler at school
Diabetes □ Yes □ No
Seizures □ Yes □ No
Special Dietary Needs □ Yes □ No   *If Yes, Explain:__________________________
Allergies □ Yes □ No   *If Yes, Explain:__________________________

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

Do child’s parents/guardians have Health Insurance? □ Yes □ No
Do child’s parents/guardians have Dental Insurance? □ Yes □ No

Household Circumstances: (Check all that apply)
□ Child’s parent is incarcerated □ Teen Parent □ Returned from Foster placement (last 6 months)
□ Child is currently experiencing grief/loss □ Substance Abuse □ Child Abuse/Neglect
□ Domestic Violence
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.

Estimation of Monthly Income of Household:

*Be sure to include any income. This means total cash receipts before taxes from all sources, grants/scholarships you receive, child support payments, unemployment, SSDI payments, military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships, and assistantships; and dividends, interest, net rental income, net royalties, and periodic receipts from estates or trusts; and net gambling or lottery winnings.

PLEASE PROVIDE ANY OF THE FOLLOWING INCOME DOCUMENTATION TO VERIFY YOUR FAMILY’S INCOME.

☐ W-2/TAX RETURN  ☐ AT LEAST THREE MONTH OF CHECK STUBS  ☐ STUDENT GRANT AWARD LETTER  ☐ TANF STATEMENT  ☐ SSI STATEMENT  ☐ UNEMPLOYMENT STATEMENT  ☐ OTHER  ☐ 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: ____________________________