2017-2018 HRDC Head Start Application

HRDC Head Start s 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

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)

□ Occupational Therapy	□Energy Assistance	□ Family Outreach	□ Hearing
□ Developmental	□ Housing Assistance	□ AWARE	□ Vision
□ Physical Therapy	□ Food Bank	□ THRIVE	□ Alcoholics Anonomous
□ Speech/Language	□ Adult Education		□ 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)

□ Child's parent is incarcerated	□ Open or previous Child Protective Services case	□ Teen Parent
□ Divorce/Separation/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?_____

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.

□ W-2/TAX RETURN	□ 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 enrollled 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: _____