Opportunities, Inc.
Helping People. Changing Lives

Head Start Prenatal to 5

EARLY HEAD START/HEAD START SERVING CHILDREN AGES 0 TO 5

How to Apply for Head Start and Early Head Start

Items to turn in for a COMPLETE application and for your child to be considered for enrollment:

- ☐ **Income Verification:** Can be last years taxes, W-2 form(s), 3 consecutive pay stubs, a letter from your employer, LES, TANF printout, or Social Security letter.
- ☐ **Birth Certificate:** Verifying your child's age and date of birth. If you have trouble obtaining the birth certificate, please let us know so we can offer support.
- ☐ **Application*:** Please read the application carefully and fill it out completely.

*If you would like assistance filling out the application please sign, date, and check the box below or give us a call at 453-5415. We are happy to set up a time to meet and support you in completing the enrollment application.

Name:_____ **Signature:**_____

Phone number: (____) - ____ - ____ ☐ I would like assistance completing the application.

Main Enrollment Office: 1220 3rd Avenue South Great Falls, MT 59405
Enrollment Main Number: 406-453-5415 **Mailing Address: P.O. Box 2289 Great Falls, MT 59403**
Fax: (406)-453-5418 **Website: oppincchanginglives.org**

Head Start Program (HS): program available for children ages 3 or 4 on or before ***September 10***.

Head Start offers the following options:

- **Center Based Part Day Programs:** 4 hours per day.
- **Full Day Programs: only offered in Great Falls:** 7 or more hours a day.

Early Head Start Program (EHS): program available for children 6 weeks-age 3, and pregnant women.

Early Head Start offers the following options:

- **Full Day Programs:** only offered in Great Falls: 7 or more hours a day.
- **Great Falls EHS Collaborative (Childcare Partnership):** only offered in Great Falls Full Day program option offered in childcares. Services provided in family and childcare centers. The hours vary depending on the childcare.
- **Home Based Program:** Weekly visits and two socialization groups a month at the center or in the community each month.

Immunization OR Conditional Enrollment record: Montana State law requires that all children must have these records on file ***before*** the child may attend Head Start or Early Head Start.

All families utilizing the Full Day program MUST complete the Best Beginnings childcare scholarship paperwork through Family Connections.

All programs are federally funded and community-based, serving low income eligible families at no cost. All programs offer structured, individualized learning environments, educational activities, social, cognitive, and physical skill(s) development, health and nutrition, parent engagement, social services, and services for children with special needs.

Opportunities, Inc.
Helping People, Changing Lives

Head Start Prenatal to 5

Important Program Information

- It is very important that we are notified with **any changes of address or phone number(s)** in the event the program would need to contact you regarding your child.
- Head Start/Early Head Start programs require your child to complete a physical and dental exam. If you need help finding a provider – we are happy to assist you.
- Additional Information you will be asked for: Any custody paperwork, parenting plans, etc. and a copy of your child's IEP/IFSP if he/she receives services.

Opportunities, Inc. Head Start Prenatal to 5 has the following locations:

(Main Office Enrollment Office for EHS/HS)
Emerson Head Start
Prenatal to 5
1220 3rd Ave. S.
P.O. Box 2289
Great Falls, MT 59403
(406)-453-5415

Annex Head Start
Prenatal to 5
1200 3rd Ave. S.
P.O. Box 2289
Great Falls, MT 59403
(406)-453-5415

McKinley Head Start
Prenatal to 5
1617 6th Ave. N.
P.O. Box 2289
Great Falls, MT 59403
(406)-866-0059

(Main Office Enrollment Office for GF EHS Collaborative)
GF EHS Collaborative
620 1st Ave. S.
P.O. Box 2289
Great Falls, MT 59403
(406)-315-1348

Conrad Head Start
312 South Wisconsin
P.O. Box 713
Conrad, MT 59425
(406)-278-7144

Shelby Head Start
1010 Oilfield Ave.
P.O. Box 154
Shelby, MT 59474
(406)-424-8838

Cut Bank Head Start
205 5th Ave. SW
P.O. Box 176
Cut Bank, MT 59427
(406)-873-4109

Opportunities, Inc. Head Start/Early Head Start does not discriminate against children or families on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status.

Opportunities, Inc. Head Start Prenatal to 5 Mission Statements:

Opportunities, Inc. Head Start Prenatal to 5 partnering within each community, provides high-quality, early intensive, comprehensive, research based education, childcare and school readiness and supports to low-income children ages birth to 5 and their families.

Opportunities, Inc.
Helping People, Changing Lives

Head Start Prenatal to 5

2022-2023 Head Start & Early Head Start Application

Application Status:
❑ New enrollment ❑ Re-enrolled Child ❑ Returning family ❑ Transfer/Transition from another Head Start/Early Head Start

Program Applying for: ❑ Head Start ❑ Early Head Start ❑ Early Head Start Childcare Partnerships ***Parents must be working or going to school full time in order to qualify for the Full Day program option. We will require additional information prior to enrollment.**

Child's First Name	Last Name	Date of Birth	Sex	Social Security #
			M F	- -

Living Address	City/State	Zip code	Home Phone #	Message #

Primary Language of applicant: ❑ English ❑Spanish ❑Other: _____

Primary Parent/Guardian:

First Name	Last Name	Date of Birth	Social Security #
			- -

Living Address	City/State/Zip	Mailing Address	City/State	Zip code

Primary Phone #	Alternate Phone #	Employer Name	Work Phone #

Email Address: _____ Preferred method(s) of contact: ❑Phone ❑Text ❑Email
Consent to receive text messages: ❑ Yes ❑ No

Relationship of Primary Care Giver to child: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Grandparent
❑ Other Relative: _____ ❑ Other: _____
Language of Primary Care Giver: ❑English ❑Spanish ❑Other: _____ Are you a veteran? ❑No ❑Yes

Secondary Parent/Guardian:

First Name	Last Name	Date of Birth	Social Security #
			- -

Living Address	City/State/Zip	Mailing Address	City/State	Zip code

Primary Phone #	Alternate Phone #	Employer Name	Work Phone #

Email Address: _____ Preferred method(s) of contact: ❑Phone ❑Text ❑Email
Consent to receive text messages: ❑ Yes ❑ No

Relationship of Secondary Care Giver to child: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Grandparent
❑ Other Relative: _____ ❑ Other: _____
Language of Secondary Care Giver ❑English ❑ Spanish ❑Other: _____ Are you a veteran? ❑No ❑Yes

Family Type:
❑ Two parent ❑ Single parent family (mother) ❑ Single parent family (father)
❑ Foster ❑ Single parent (mother) living with a partner ❑ Single parent (father) living with a partner
❑ Grandparent(s) ❑Other Relative(s) ❑ Other family type: _____

Custody: Are you a joint custody family? (Joint custody means care and support is shared between both parents who are residing in separate households.) ❑No ❑Yes Do you have a parenting plan? ❑No ❑Yes

If you are not the child's parent do you have Legal Guardianship of this child through the court system or have a Special Power of Attorney? ❑No ❑Yes ***If yes, we will need a copy of the paperwork for our files.***
Do you have a Temporary Restraining Order (TRO), Parenting Plan, or Court Papers regarding custody? ❑No ❑Yes
If yes, we will need a copy of the paperwork for our files

Is either parent in jail or prison? ❑No ❑Yes If yes, which parent? _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Opportunities, Inc. Head Start Prenatal to 5
2022-2023 Head Start & Early Head Start Application

Current Living Situation: ❑Own ❑Rent ❑Receive Subsidized Housing ❑Homeless
❑Sharing due to loss of housing/economic hardship ❑Other:_____
Housing Type: ❑Apartment ❑House ❑ Duplex ❑Mobile Home ❑Community Shelter ❑Hotel/Motel ❑Other:_____
Number of times family/child has moved in the past 24 months:
❑Once ❑Twice ❑Three ❑Four+ ❑Family has not moved in the past 12 months
Transportation: Family currently has means of transportation. ❑No ❑Yes
Primary mode of transportation: ❑Private vehicle ❑Friend ❑Relative ❑Public Transportation ❑Other: _____
Disabilities: Are any members of your household disabled? ❑ No ❑ Yes
If yes, will they need any special accommodations for you to attend activities at Head Start? ❑ No ❑ Yes
Please list: _____

WHAT SERVICES ARE YOU CURRENTLY RECEIVING? (Please check all that apply)

❑ Opportunities, Inc. (*which services*): _____ _____	❑ Child Support	❑Child and Family Services	❑ Youth Dynamics
	❑ TANF Benefits	❑ Domestic Violence Support Services	❑ A.W.A.R.E.
	❑ SNAP (Food Stamps)	❑ Job/Skills Training Program	❑ WIC
	❑ Public Housing	❑ Center for Mental Health	❑ Youth Employment
❑ Quality Life Concepts	❑ Social Security	❑ City County Health Department	❑ Childcare Subsidy
❑ Special Education Pre-K	❑ Vocational-Rehab	❑ Benchmark Human Services	❑ Other: _____

Are you working towards your HiSET(GED)through Adult Education ❑No ❑Yes If not are you attending college now? ❑No ❑Yes
If you are not receiving SNAP (Food Stamps), would you like an application to apply for SNAP? ❑Yes ❑No ❑N/A

Family Member Information: ***(Insert Codes for all family members below.)***

Race: **B** = Black/African American **W** = White **N** = Native American **A** = Asian **P** = Pacific Islander **BM** =Biracial/Multiracial

Education years: **G09** = Grade 9 or less **G10** = Grade 10 **G11**= Grade 11 **G12** = Grade 12 - *but did not Graduate*
HSG = High School Graduate **HiSET(GED)**=HiSET **COL**= Some college or Associates Degree **B** = Bachelor's Degree or Higher

★ **Please list *all* family members and persons living in your home including the applicant.**

First Name **(Please Print)**	Last Name	Social Security #	Date of Birth	Sex	Race	Ethnicity (circle one)	Education Level
				M F		Hispanic or Non-Hispanic	
				M F		Hispanic or Non-Hispanic	
				M F		Hispanic or Non-Hispanic	
				M F		Hispanic or Non-Hispanic	
				M F		Hispanic or Non-Hispanic	
				M F		Hispanic or Non-Hispanic	
				M F		Hispanic or Non-Hispanic	
				M F		Hispanic or Non-Hispanic	

EMPLOYMENT/HOUSEHOLD INCOME Proof of income is required for eligibility (paystubs, last year's taxes, W2, etc.)
List all forms of income: Employment, TANF payments, Child Support, Social Security/Disability, Unemployment, etc. for all household members.

Parent/Guardian 1 Employment: (Check All that Apply)
❑Full Time ❑ Part Time ❑Seasonal ❑ Military
❑Training/School Part Time ❑ Training/School Full Time
❑Retired ❑Disabled ❑Stay at Home
❑Self-Employed ❑Unemployed (last day worked:)

Parent/Guardian 2 Employment: (Check All that Apply)
❑Full Time ❑ Part Time ❑Seasonal ❑ Military
❑Training/School Part Time ❑ Training/School Full Time
❑Retired ❑Disabled ❑Stay at Home
❑Self-Employed ❑Unemployed (last day worked:)

Other Sources of Income: ❑TANF ❑SSI ❑SSDI Payments ❑Child Support ❑School Grants/Scholarships ❑Other:

Name **List Head of Household first**	**Place of Employment**	**Income Source:** ***Employment, TANF, SSI, Child Support, etc.***	**Total Income Per Month**

FOR FAMILIES WITH NO INCOME: I declare that my family has no income due to the following reasons: *You may attach another sheet of paper to application if needed.* _____
_____

I certify that the information provided in this application is correct and complete to the best of my knowledge, including information about each household member. If any of the information I have provided in my application is false, my participation in the Opportunities, Inc. Head Start Prenatal to 5 program may be terminated.

Parent/Guardian Signature: _____ **Date:** _____ **(Staff Initials:** _____**)**

RESOURCE/REFERRAL NEEDS: I have the following needs for myself or another adult household member:
(Please check all that apply)

❑ Homeless ❑ Food ❑ Clothing ❑ Emergency/Crisis Assistance ❑ Help paying for child care ❑ Domestic Violence	❑ Job Training ❑ Literacy/Education ❑ Adult Education (HiSet) ❑ Transportation ❑ Mental Health	❑ Disability Services or Resources ❑ Child Support Assistance ❑ Health Education (to include Prenatal) ❑ Substance Abuse/Prevention ❑ English as a second language	❑ Marriage Education ❑ Parenting Education ❑ Support for families who have incarcerated members ❑ Other: _____ ❑ Other: _____

Do you have a working refrigerator and stove/oven in your home? ❑No ❑Yes If no, what are you missing? _____

How did you hear about Head Start? ❑ Family/Friend ❑ Media/Flyer ❑ Agency ❑ Had other children in the program
❑ Other: _____

Child Care Information:

Do you receive a Child Care Scholarship through Family Connections? ❑No ❑Yes

Is your child currently attending a daycare or preschool program? ❑No ❑Yes If so, please list: _____

Has your child ever attended a daycare or preschool prior to Head Start/Early Head Start? ❑ Yes ❑ No

In addition to participating in our program, will you be using other sources of child care by someone other than you or your partner?
❑No ❑Yes ***If yes***, what hours of the day will the other sources be providing care? _____

If yes, where will the care be provided? ❑At home (Who will provide the care in your home?) _____
❑Relative _____ ❑ Child Care Center _____
❑Private Child Care Home _____ ❑ Other _____

Primary Parent/Guardian Work Schedule:

	MON	TUES	WED	THUR	FRI	SAT	SUN
Start Time:	_____	_____	_____	_____	_____	_____	_____
End Time:	_____	_____	_____	_____	_____	_____	_____

Pay Days: ❑ weekly, ❑ every two weeks, ❑ monthly, or ❑ twice-a-month

Average number of work hours per week: _____ if work schedule varies, please explain: _____

Secondary Parent/Guardian Work Schedule:

	MON	TUES	WED	THUR	FRI	SAT	SUN
Start Time:	_____	_____	_____	_____	_____	_____	_____
End Time:	_____	_____	_____	_____	_____	_____	_____

Pay Days: ❑ weekly, ❑ every two weeks, ❑ monthly, or ❑ twice-a-month

Average number of work hours per week: _____ if work schedule varies, please explain: _____

CLASS TIMES:

There is no guarantee of your child's class placement. Class times vary due to location and bus routes. What time of day works best for your schedule?

Part Day Services: ❑ a.m. - morning class ❑ mid-day class ❑ p.m. - afternoon class ❑Other (please list):
Full Day Services: ❑Full day *10 hours a day* ❑Full day *7 hours a day* ❑Full day *8 hours a day*

HEAD START PART DAY ONLY *Children in Head Start Full Day or Early Head Start are not eligible for transportation services.*

Busing Information: Do you need transportation services for your child to attend Head Start?* ❑ Yes ❑ No

Pick-up Address: _____ Drop-off Address: _____
We will need additional information from you to consider the possibility of providing this service.

Note: If the pick-up and drop-off addresses are left blank we will assume transportation is not needed. *Head Start tries to provide busing to Part Day Center Base Head Start children whenever possible. There is no guarantee busing will be provided. In addition, due to weather and other safety conditions bus services may not be provided.

Parent/Guardian Signature: _____ **Date:** _____ **(Staff Initials: _____)**

Health/Nutrition Information:

1. Does your child have allergies? ❑No ❑Yes If yes, please explain:_____
2. What type of reaction does your child have from any allergies? _____
3. Does your child take any medications? ❑No ❑Yes If so, what medications? _____
4. Are there any foods your child should not eat for medical, personal or religious reasons? ❑No ❑Yes
   If yes, what foods? _____
5. Does your child have trouble with: ❑Chewing ❑Swallowing
6. Does your child need special accommodations to eat solid foods? ❑No ❑Yes Explain:_____
7. Does your child choke easily on foods? ❑No ❑Yes
8. For Child under 1: What type of formula does your child drink? _____
9. Child over 1: Does your child chew on things that are not food? ❑No ❑Yes Please name: _____
10. **Does your child have any chronic health concerns?**
    ❑Asthma ❑Seizures ❑Diabetes ❑Bleeder ❑Heart Conditions ❑Other:
    Please explain: _____
11. **Does your child frequently experience any of the following?**
    ❑ Colds ❑ Ear aches/infections ❑ Pneumonia ❑ Bronchitis ❑ Bruising ❑ Vomiting ❑ Stomach Pain
    ❑ Croup ❑ Constipation ❑ Diarrhea ❑ Nose Bleeds ❑ Headaches ❑ Muscle/body aches
12. Are there any other health conditions/illnesses that affect your child's day to day activities? ❑Yes ❑No
    If yes, please explain:_____
    **If you checked any health concerns additional paperwork may need to be completed with the Health Coordinator.*
13. Is your family currently expecting a baby? ❑No ❑Yes Due Date: _____
14. Does your child require special diapers due to irritation of the skin or rashes? ❑No ❑Yes If so, what brand? _____

Insurance/Provider Information:

1. Does your entire family have Health Insurance? ❑No ❑Yes ❑Children only ❑ Parent(s) only
2. If your ***child(ren)*** has insurance what type of insurance coverage do they have?
   ❑Medicaid ❑Healthy Montana Kids ❑Private health insurance to include: ❍ Vision coverage ❍ Dental Coverage
   ❑TRI-Care ❑Other coverage: _____
3. If ***you*** have insurance what type of insurance coverage so you have?
   ❑Medicaid ❑Medicaid Expansion ❑Private health insurance to include: ❍ Vision coverage ❍ Dental Coverage
   ❑TRI-Care ❑Other coverage: _____
4. If you **do not** have health insurance for yourself or your child, have you applied for Medicaid? ❑No ❑Yes – in progress
5. Is your child up-to-date on immunizations? ❑No ❑Yes
6. Do you have a current Physician for your child? ❑No ❑Yes Date of last Well-Child Check-up: _____
7. Do you have a current Dentist for your child? ❑No ❑Yes Date of last Dental Check-up: _____

Alternative Emergency Contacts:	**To be contacted only if Parent(s)/Guardian(s) cannot be reached.**	
Emergency Contact # 1:	**Relationship:**	**Phone:**
Emergency Contact # 2:	**Relationship:**	**Phone:**

Medical Information

_____ _____
Hospital/Clinic Name and phone # **Physician's Name**

_____ _____
Insurance **Policy #**

I authorize Head Start to consent to all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. ***This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.***

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Staff Signature/Witness: _____ **Date:** _____

Education/Special Needs/Disabilities:

Does your child need support in any of the following areas? (If YES, please check)

❑Developmental ❑Behavior Concerns ❑Speech/Language ❑Other:

Has your child been diagnosed with any of the following? (If YES, please check)

❑Visual Impairment ❑Hearing Impairment ❑Learning Disability ❑Traumatic Brain Injury
❑Autism ❑Development Delay(s) ❑Orthopedic Impairment ❑Emotional/Behavioral Disorder
❑Attention Deficit Disorder ❑Down Syndrome ❑Other: ❑Other:

Does your child currently have an IEP/IFSP? ❑ Yes (please attach copy) | ❑No | ❑In evaluation process/testing

If yes, what district or provider?

Does your child require any special equipment or accommodations for disabilities? ❑Yes ❑No ❑NA

Please note any accommodations needed: _____

Is your child currently receiving ❑Speech Therapy ❑Occupational Therapy ❑Physical Therapy ❑ Other: _____

If your child is receiving any of these services; what is the name of the treating service provider/physician/therapist(s)?

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Child Development:

1. Did you have any concerns about when your child started to: ❑Sit without help ❑Crawl ❑Walk ❑Talking ❑NA
2. Do you have any concerns in any other areas of development? ❑No ❑Yes If yes, what are your concerns? _____

_____

Please answer the following questions for children OVER THE AGE OF 18 MONTHS:

Separation from Parent/Guardian: How does your child separate from Parent/Guardian?
❑With no difficulty ❑ With some difficulty ❑ Has a very difficult time separating
Do you have any concerns about your child's behavior? ❑No ❑Yes

Frequent or undesirable/unpleasant behaviors:
❑Crying ❑Tantrums ❑Fearful ❑Anxious ❑Withdrawn ❑Appears sad ❑Restless ❑ Sensory Issues
❑Difficulty with change ❑Mood swings ❑No concerns

Destructive behaviors:
❑Tries to hurt self ❑Tries to hurt other children ❑Tries to hurt adults ❑Tries to break objects or toys ❑No concerns
❑Excessive movement

Nervous Habits:
❑Puts hands or fingers in mouth most of the time ❑Fidgets or "fiddles" with hands, small objects, clothing, etc. ❑No concerns

Sleeping problems:
❑Walks in sleep ❑Afraid to close eyes ❑Bad dreams ❑No concerns

How does your child get along with other children?
❑Problems getting along with other children ❑Uncooperative/bothers or interferes with others ❑No concerns
❑Prefers to talk with only children ❑Hits or physically fights with other children
❑Avoids other children; does not interact with them ❑Yells or calls names

How does your child get along with adults:
❑Runs from adults ❑Will not follow direction from adult authority ❑Hits or physically fights with adults
❑Clings to adults ❑Avoids adults; does not interact with them ❑No concerns
Do you have concerns with other children in the home? ❑No ❑Yes If yes, age of the child/children you have concerns about:
❑0-5 ❑6+ or older Behavior Concerns: _____

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

_____

_____

_____

I, _____, understand that Head Start is required by law to report any suspected child abuse and/or neglect to the local Department of Child Protective Services.

Parent/Guardian Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____