Opportunities, Inc.

2024-2025 Head Start Prenatal to 5 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 ***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 Primary 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: _____

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: ❑**1** ❑**2** ❑**3** ❑**4 +** ❑Have 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
❑ Youth Employment	❑ TANF Benefits	❑ Domestic Violence Support Services	❑ A.W.A.R.E.
❑ Quality Life Concepts	❑ SNAP (Food Stamps)	❑ Job/Skills Training Program	❑ WIC
❑ Special Education Pre-K	❑ Public Housing	❑ Center for Mental Health	❑ Childcare Subsidy
	❑ Social Security	❑ City County Health Department	❑Toby's House/Crisis Nursery
	❑ 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** = American Indian **A** = Asian **P** = Pacific Islander **BM** =Biracial/Multiracial

Education years: **HSG =** High School Graduate **HiSET(GED)=**HiSET **G12 =** Grade 12 - ***but did not Graduate***
G9 = Grade 9 or less **G10 =** Grade 10 **G11=** Grade 11 **COL=** Some college/Associates Degree **B =** Bachelor's Degree /Higher

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

First Name **(Please Print)**	Last Name	Social Security Number	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, 1040 form, W2, etc.)
List all forms of income for all in the household: Employment, TANF payments, Child Support, Social Security/Disability, & Unemployment, etc.

Parent/Guardian 1 Employment: (Check All that Apply)	**Parent/Guardian 2 Employment: (Check All that Apply)**
❒Full Time ❒ Part Time ❒Seasonal ❒ Military ❒Retired	❒Full Time ❒ Part Time ❒Seasonal ❒ Military ❒Retired
❒Training/School Part Time ❒ Training/School Full Time	❒Training/School Part Time ❒ Training/School Full Time
❒Disabled ❒Stay at Home ❒Self-Employed	❒Disabled ❒Stay at Home ❒Self-Employed
❒Unemployed last day worked:____/____/____	❒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.* _____

_____

Signature of Parent/Guardian_____

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.***

Signature of Parent/Guardian_____ Date: _____

Staff Signature: _____ Date: _____

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 Family Connections/Best Beginnings Childcare Scholarship? ❑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 *minimum 7 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.

Signature of Parent/Guardian_____ Date: _____

Staff Signature: _____ Date: _____

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. My child/family uses Indian Health Services (IHS) ❑No ❑Yes
5. If you **do not** have health insurance for yourself or your child, have you applied for Medicaid? ❑No ❑Yes – in progress
6. Is your child up-to-date on immunizations? ❑No ❑Yes
7. Do you have a current Physician for your child? ❑No ❑Yes Date of last Well-Child Check-up: _____
8. 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: _____

Signature of Parent/Guardian_____ Date: _____

Staff Signature: _____ 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.

Signature of Parent/Guardian_____ Date: _____

Staff Signature: _____ Date: _____