



Opportunities, Inc.

Head Start serving children ages Birth to 5

How to Apply for Head Start

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

- Income Verification:** Can be last year's taxes, W-2 form(s), 3 consecutive pay stubs, a letter from your employer, LES, TANF, SNAP 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.
- 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.

*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 Head Start Office: 1220 3rd Ave 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: oppinchanginglives.org

Important Program Information

We offer the following Head Start Program Service


- Head Start Preschool (HS):* program available for children ages 3 or 4 on or before *September 10th*.
- Early Head Start (EHS):* program available for children 6 weeks-age 3

All families utilizing the Full Day program (7-10 hours a day) MUST complete the Best Beginnings childcare scholarship paperwork through Family Connections.

We require your child to have an up to date 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.

 It is very important that we are notified of **any changes of address or phone number(s)** in the event the program needs to contact you regarding your child.

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. Head Start Birth to 5 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.



2026-2027 Head Start Birth 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: <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email	
Consent to receive text messages: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email	
Consent to receive text messages: <input type="checkbox"/> Yes <input type="checkbox"/> 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)

<input type="checkbox"/> Opportunities, Inc. (which services): _____	<input type="checkbox"/> Child Support <input type="checkbox"/> TANF Benefits <input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> Public Housing <input type="checkbox"/> Social Security <input type="checkbox"/> Vocational-Rehab	<input type="checkbox"/> Child and Family Services <input type="checkbox"/> Domestic Violence Support Services <input type="checkbox"/> Job/Skills Training Program <input type="checkbox"/> Center for Mental Health <input type="checkbox"/> City County Health Department <input type="checkbox"/> Benchmark Human Services	<input type="checkbox"/> Youth Dynamics <input type="checkbox"/> A.W.A.R.E. <input type="checkbox"/> WIC <input type="checkbox"/> Childcare Subsidy <input type="checkbox"/> Toby's House/Crisis Nursery <input type="checkbox"/> Other:
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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.)

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/Associate's Degree B = Bachelor's degree /Higher

Race &/or Ethnicity: N = American Indian or Alaska Native A = Asian B = Black or African American H = Hispanic or Latino
 M = Middle Eastern or North African P = Native Hawaiian or Pacific Islander W = White MM = Multiracial &/or Multiethnic

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

First Name (Please Print)	Last Name	Social Security Number	Date of Birth	Sex	Race and/or Ethnicity	Education Level
				M F		
				M F		
				M F		
				M F		
				M F		
				M F		
				M F		

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) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Military <input type="checkbox"/> Retired <input type="checkbox"/> Training/School Part Time <input type="checkbox"/> Training/School Full Time <input type="checkbox"/> Disabled <input type="checkbox"/> Stay at Home <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed last day worked: / /	Parent/Guardian 2 Employment: (Check All that Apply) <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Military <input type="checkbox"/> Retired <input type="checkbox"/> Training/School Part Time <input type="checkbox"/> Training/School Full Time <input type="checkbox"/> Disabled <input type="checkbox"/> Stay at Home <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed last day worked: / /
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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 Birth 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)

<input type="checkbox"/> Homeless <input type="checkbox"/> Food <input type="checkbox"/> Clothing <input type="checkbox"/> Emergency/Crisis Assistance <input type="checkbox"/> Help paying for childcare <input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Job Training <input type="checkbox"/> Literacy/Education <input type="checkbox"/> Adult Education (HiSet) <input type="checkbox"/> Transportation <input type="checkbox"/> Mental Health	<input type="checkbox"/> Disability Services or Resources <input type="checkbox"/> Child Support Assistance <input type="checkbox"/> Health Education (to include Prenatal) <input type="checkbox"/> Substance Abuse/Prevention <input type="checkbox"/> English as a second language	<input type="checkbox"/> Marriage Education <input type="checkbox"/> Parenting Education <input type="checkbox"/> Support for families who have incarcerated members <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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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 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 childcare 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:	<input type="checkbox"/> weekly, <input type="checkbox"/> every two weeks, <input type="checkbox"/> monthly, or <input type="checkbox"/> 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:	<input type="checkbox"/> weekly, <input type="checkbox"/> every two weeks, <input type="checkbox"/> monthly, or <input type="checkbox"/> twice-a-month						
Average number of work hours per week:	_____ if work schedule varies, please explain: _____						

CLASS TIMES:

Will you be utilizing other childcare services, outside of the Opportunities, Inc. Head Start Birth to 5 services?

Yes No If yes where will care be provided? With a relative At another childcare center
 At a family childcare Other _____

What hours does your child need care? 7:30 am-5:30 pm 9:00 am- 3:00 pm 10:00 am-2:00 pm 11:30 am-3:30 pm
 Prior to 7:30 am After 5:30 pm Overnight care Other _____

What class times would best meet your needs? A.M. class time P.M. class time Full day services

(There are no guarantees of your child's class placement)

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 food? No Yes
For Child under 1: What type of formula does your child drink? _____
Child over 1: Does your child chew on things that are not food? No Yes Please name: _____
8. **Does your child have any chronic health concerns?**
Asthma Seizures Diabetes Bleeder Heart Conditions Other:
Please explain: _____
9. **Does your child frequently experience any of the following?**
Colds Earaches/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 do 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:

- Did you have any concerns about when your child started to: Sit without help Crawl Walk Talking NA
- 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: _____