

2011 APPLICATION



Ravalli Early Head Start

103 South 9th Street, Suite 106 Hamilton MT

406-363-7412

Name of Parent(s)/Guardian(s)/Prenatal Mother:

Two Parents Single Parent Other (Relative/Guardian) _____

Which option are you applying for? Prenatal Center-Based Home-Based Either Center or Home

For Center-Based: Employed Full-Time (30+hrs) School Other _____

Current Employer (both parents): _____ Current School: _____

FILL OUT THIS SECTION IF YOU ARE APPLYING FOR THE PRENATAL PROGRAM

Prenatal Mother's Name _____

BABY'S DUE DATE: ___/___/___ Is the pregnancy considered "High Risk"? Yes No

Skip down to the "Address" section

Child's Name: _____

Child's Date of Birth: ___/___/___

Gender: Male Female

Address: _____

Street and/or Apartment #

City

State

Zip Code

Day Time Phone: _____ Evening Phone: _____

E-MAIL: _____

In case your family moves during the application process, please list another person who would know how to contact you.

Name/Relationship: _____ Phone: _____

Early Head Start defines a family as all persons living in the same household who are:

1. Related to the parent(s) or guardian(s) by blood, marriage, or adoption, **AND**
2. Supported by the income of the parent(s) or guardian(s) of the child enrolling in Early Head Start.

(Both 1 AND 2 must apply to be considered part of your family).

Parents in Household: 1 Parent 2 Parents in same household Foster Parent(s) Other _____

Total Adults & Children: In Household ____ In Family ____ Related children in family: _____

Language(s) spoken in the home: _____

How did you find out about Early Head Start? _____

Have you or your child(ren) participated in Early Head Start or Head Start? _____

- Yes I give my permission to share my information, included above, with Ravalli Head Start.
- No I DO NOT give my permission to share my information, included above, with Ravalli Head Start.

Do you have any special concerns about your child (Example: health, development, etc.)? _____

Does your child have a developmental delay or disability? No Yes (IFSP/IEP Diagnosed Suspected)

Please describe delay/disability & your consultant: _____

Please check all that apply: Teen Parent First Time Parent

Please check income and benefits received by your family:

INCOME: Public Assistance/TANF (TANF Case # _____) SSI (Parent/Child) Child Support

Unemployment Workers Comp Alimony Tribal Grants/Scholarships

Foster Child/Adoption Subsidy Other Cash Assistance (Trusts, Inheritance, Financial Aid, etc.)

BENEFITS: State-Funded Childcare/Scholarship WIC Food Stamps

Medicaid/Medicare Housing Assistance CHIP Energy Assistance

WORC – WEX – FESS Employment Program(s) Tribal Financial Aid Other _____

Please note any other family issues/concerns you want to share (Example: homelessness, health, transportation, military deployment, incarceration, rehab, etc.). You may attach additional page if you would like:

By signing this document I am stating that all personal information, including financial statements, are accurate to the best of my knowledge.

Parent/Guardian Signature Date

Other Parent/Guardian Signature (optional) Date

Confidentiality Statement: All information shared with Ravalli Early Head Start will be kept strictly confidential, unless a release is authorized in writing.
Non-Discriminatory Clause: U.S. Federal Law prohibits Ravalli Early Head Start from discrimination on the basis of race, sex, age, color, national origin, or disabilities in provision of services and employment.