Confederated Salish and Kootenai Tribes
Early Childhood Services (ECS)
Early Head Start, Head Start, Child Care
Family Application

School Year: 2024-2025

The information given is confidential. You are not required to provide this information, however, Incomplete or inaccurate information may prevent us from determining your eligibility for the ECS. If you need assistance completing application, please call (406)745-4509 Ext 5523

Child's First Name:	Middle Name:	Child's Last Name:	Date of Birth	☐ Male ☐ Female

Child's Race:☐ Enrolled CSKT ☐ CSKT Descendant ☐ Enrolled/Descendant *other* Tribe_____
(Provide Documentation)
☐ Alaskan Native ☐ Asian ☐ Hispanic ☐ African American ☐ Multi-Racial ☐ Pacific Islander ☐ Other

How did you hear about Early Childhood Service? ☐ Community Event ☐ Flyer/Poster ☐ Family/ Friend? ☐ Mailing ☐ Public Advertisement ☐ Former Parent ☐ Community Partner Referral ☐School District

Family Receives: **(Check all that applies)**
TANF ☐Yes ☐No
SNAPS ☐Yes ☐No
SSI ☐Yes ☐No
WIC ☐Yes ☐No

Parent Education Level: **(Check all that applies)**
Advanced Degree or Baccalaureate ☐
Associate Degree, Vocational or Some College ☐
High School Graduate or GED ☐
Less than HS Diploma ☐

Family Dynamics ☐One Parent ☐Two Parent ☐Dual Custody(50/50) Equal shared Parenting ☐ Teen Parent
Homeless: ☐Yes ☐ No **Number of People in home**_____

PARENT/GUARDIAN INFORMATION:

Parent/Legal Guardian Date of Birth:

Living Address: Mailing Address:

Phone #: Cell # Work #

Email:

Ethnic Group Race:☐ Enrolled CSKT ☐ CSKT Descendant ☐ Enrolled *other* Tribe
☐ Alaskan Native ☐ Asian ☐ Hispanic ☐ African American ☐ Multi-Racial ☐ Pacific Islander ☐ Other

Relationship to Child: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other
(Copy of Placement) (Copy of Placement)

Employment Status:☐ Full Time ☐Part Time ☐Seasonal ☐ Student ☐Self-Employed ☐Unemployed, Retired, Disabled

Active Member of the Military ☐ No ☐ Yes **Veteran of the US Military** ☐ No ☐ Yes

PARENT/GUARDIAN INFORMATION:

Parent/Legal Guardian: Date of Birth:

Address:

Phone #: Cell # Work #

Email:

Ethnic Group Race:☐ Enrolled CSKT ☐ CSKT Descendant ☐ Enrolled *other* Tribe
☐ Alaskan Native ☐ Asian ☐ Hispanic ☐ African American ☐ Multi-Racial ☐ Pacific Islander ☐ Other

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Employment Status:☐ Full Time ☐Part Time ☐Seasonal ☐ Student ☐Self-Employed ☐Unemployed, Retired, Disabled
Active Member of the Military ☐ No ☐ Yes **Veteran of the US Military** ☐ No ☐ Yes

Child's Information

Does your child have any Special Requirements for Medical or Nutritional Needs?
☐ No ☐ Yes If Yes, please list: _____

Primary Health Insurance:☐ CHIP ☐ Medicaid ☐ IHS/Tribal Health ☐Private ☐No Insurance

Dr./Medical Home: _____ Dentist/Dental Home: _____
DISABILITY STATUS: ☐ Zero ☐ Suspected ☐ Certified Date of IEP/IFSP:_____
(Please provide a copy so ECS may begin coordinating services as soon as possible)
Do You have concerns about your child's development?
☐ No ☐ Yes If Yes, Please list:_____

_____

Family Interested in the Following Type of Service

Early Head Start

Designed to provide services to families and children age 6 weeks to 3 years (must be less than age 3 by September 10th) that nurture social, emotional, health, educational and nutritional needs.

Available Sites 0-3 Center Based Services
(Check Box for Site)

☐ Arlee ☐ St. Ignatius ☐ Eskwalmi Nuwewlstn (Salish Language St. Ignatius) ☐ Ronan

☐ Pablo (5th Ave) Child Care * ☐ Pache (Ronan area) ☐ Turtle Lake (Polson Area) (Availability based on Need)

Child Care Sites* ***1st Choice:***_____ ***2nd Choice:***_____
Montana State Rates Apply: Rates are subject to change
Rates are subject to change

Children enrolled in Early Head Start services are not charged for that portion of the day. Child Care hours before and after Early Head Start or Head Start equal a full day of service and are charged a full day rate. Rates above apply.
Early Childhood Services staff is available to assist families in applying for Child Care payment help through the Child Care Block Grant and the Nurturing Center

Head Start

Designed for children age 3 years to 5 years (Child must be age 3 or 4 by September 10th of the program year)
(Check Box for Site)

☐ Arlee ☐ St. Ignatius ☐ Ronan ☐ Polson

☐ Pablo College Drive Child Care* ☐ Pablo 1 & 2 ☐ Turtle Lake (Polson Area) (Availability based on Need)

Child Care Sites* ***1st Choice:***_____ ***2nd Choice:***_____
Montana State Rates Apply: Rates are subject to change

Children enrolled in Head Start Services are not charged for that portion of the day. Child Care hours before and after Early Head Start or Head Start equal a full day of service and are charged a full day rate. Rates above apply.
Early Childhood Services staff is available to assist families in applying for Child Care payment help through the Child Care Block Grant and the Nurturing Center

Other Services: (Services are for children with Suspected Delays) Not Income Based

☐Part C Services Birth-3yrs (Services for infant/toddler w/disabilities) ☐ Part B Services 3-5 year for Medically/Necessary/Preventive

Family Information

Please list all the people in the household

First & Last Name	Age	Date of Birth	Sex(M)(F)	Relationship to Child

Documentation Needed If Applicable

Tribal Enrollment or Descendant
Recent Benefit Statement from TANF/SNAPS
Homeless Declaration

Proof of Birth

Head Start Program requires that we verify date of birth, so please provide a copy of your child's birth Certificate.

Other acceptable documents:
Tribal ID
Health Insurance Card
US Passport
Child Custody Documentation (If applicable)

Please take the time to review your Child's Application

Check to make sure all requested information is present; especially the information that states it is required for the application to be processed. Sending in an incomplete application slows the process as the necessary information is gathered and *may make the difference between a placement in a center and being placed on a waiting list*. Thank you for applying to our program and we hope to visit with you soon. Call 745-4509, ext. 5523 with any questions you may have about the application process or the programs offered.

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

Before Typing/Signing application, verify that the content you are signing is correct and true.
By typing your name this will be considered a signature on the application.

Application *cannot* be processed without signature/date, number of people in the home and Applicable Documentation Needed: Tribal/Descendant Documentation, Public Assistance (SNAP), Foster Care or Homeless Declaration.

Upon acceptance, please be prepared to provide a copy of supporting documentation regarding health insurance; diagnosed health condition; or **IEP** (Individualized Education Plan) or **IFSP** (Individualized Family Services Plan)

Child Application

P.O. Box 1510
35455 Mission Drive
St. Ignatius, MT 59865
Phone: (406) 745-4509
Fax: (406) 226-2697
Email: headstart@cskt.org

Office Use

Face to face Interview by:_____Date:_____

Phone Interview by:_____Date:_____

Contact Notes:

_____

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For Office Use: Date Entered_____Initials_____

Child Plus ID:_____