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

School Year: 2026-2027

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 ECS. If you need assistance completing the application, please call (406)745-4509 Ext 5523

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

(Provide Tribal Documentation)

Child's Race:☐CSKT Enrolled ☐CSKT Descendant ☐Other Tribe Enrolled/Descendant_____
☐ 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) ☐ Teen Parent
Homeless: ☐Yes ☐ No **Number in Household**_____

PARENT/GUARDIAN INFORMATION:

Parent/Legal Guardian **Date of Birth:**

Mailing Address: **City:** **Zip Code:**

Physical Address: **City:** **Zip Code:**

Phone #: **Work #** **Email:**

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

Relationship to Child: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other

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:**

Mailing Address: **City:** **Zip Code:**

Physical Address: **City:** **Zip Code:**

Phone # **Work #** **Email:**

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

Relationship to Child: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other

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

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Child's Information

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

_____

Disability Status: ☐ None ☐ Suspected ☐ Diagnosed, provide a copy of IEP/IFSP:

_____

Do You have concerns about your child's development?
☐ No ☐ Yes If Yes, Please list:_____

Dr./Medical Home: _____ **Dentist/Dental Home**: _____

Primary Health Insurance: ☐Healthy MT Kids ☐ Medicaid ☐ IHS/Tribal Health
(Mark All That Apply) ☐Private ☐No Insurance

_____

Family Interested in the Following Type of Service

Early Head Start

Designed to provide services to families and children ages 6 weeks to 3 years ***(Child must be less than age 3 by September 10th of the program year)***

Check Box for Site

☐ Arlee ☐ Eskwalmi Nuwewlstn (St. Ignatius) ☐ Ronan ☐ Pache (Ronan) ☐Turtle Lake (Polson)

** ☐ Pablo Early Child Care

1st Choice:_____ ***2nd Choice:***_____

***** Child Care Sites: Montana State Rates Apply: Rates are subject to change***
Children enrolled in Early Head Start services are not charged for Early Head Start hours. Child Care hours before and after Early Head Start are charged a full or half-day rate based on daily hours attended. See ECS Childcare Contract for further details.

Head Start

Designed for children aged 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 ☐Pablo ☐Polson ☐Fun and Fancy (Polson child care)

**☐ Pablo College Drive Child Care

1st Choice:_____ ***2nd Choice:***_____

*****Child Care Sites: Montana State Rates Apply: Rates are subject to change***
Children enrolled in Head Start services are not charged for Head Start hours. Child Care hours before and after Head Start are charged a full or half-day rate based on daily hours attended. See ECS Childcare Contract for further details.

Other Services: **(Support for children with documented delays or medical concerns)**

☐Part C Services Birth-3 yrs. ☐ Part B Services 3-5 yrs.

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 Documentation
Recent Benefit Statement from TANF/SNAPS
Homeless Declaration
Foster Care Documentation

Proof of Birth

The Head Start Program requires verification of date of birth. Provide a copy of your child's Birth Certificate.

Other acceptable documents:
Tribal ID
Health Insurance Card
US Passport
Child Custody Documentation

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 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 the application, verify that your content is correct and true.
By typing your name this will be considered a signature on the application.

The 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, Homeless Declaration, or Birth Certificate.

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

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:

_____

_____

_____

_____

_____

_____

_____

For Office Use: Date Entered _____ **Initials** _____

Child Plus ID: _____

Early Childhood Services

Homeless Declaration Form

(Leave Blank if Not Applicable)

Parent's Name: ..... Date: .....

Child's Name: ..... 0.O.B: .....

This questionnaire is intended to assist in determining if a student meets the eligibility criteria for services provided under the McKinney-Vento Act 42 U.5.C. 11235

The above child, who has applied for the Early/Head Start Program, meets the following criteria:

Does any of these apply to you?

D **Fixed:** A fixed residence that is stationary, permanent, and not subject to change.

D **Regular:** A regular fixed residence is one which is used on a predictable or routine basis

D **Adequate:** An adequate residence is one that is sufficient for meeting both physical psychological needs Typically met in home environments.

(If you checked one of the boxes do not proceed with next section)

Check one that applies to your living situation

D Staying in an emergency /transitional shelter

D Awaiting foster care placement

D Sharing the housing of others due to loss of housing, economic hardship, or similar reason;

D Staying in a hotel/motel due to loss of housing, economic hardship, or similar reason;

D Living in a car, park, campground, public space, abandoned building, or substandard housing;

D Unknown nighttime residence

Describe the child's living situation:

_____

_____

_____

_____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _ _ _ _ _ _ _ _ _ _