

1020 Cook Avenue Billings, MT 59102 Phone: 406-259-2007 Fax: 406-259-4901

Application Checklist YFEHS

Please complete the attached application and gather the information listed below.

When you are ready to submit your application,

please make sure all supporting documents are included and return to:

YFEHS – 1020 Cook Avenue,

Billings, MT 59102.

Proof of Income Gross wages (W2 OR tax return) Pay stubs Child support payment information TANF (child only), SNAP or SSI payment verification
Financial aid (award letter for school)Disability paymentsOther
Birth Certificate or Proof of Birth Date (Child)
Proof of Residency (utility bill, rent receipt or mail)
Legal Documents (custody, parenting plans, placement letters, orders of protection, etc.)
*Our Enrollment is limited. We do not have space to accept every family who applies for Early Head Start. Please complete and return your paperwork as soon as possible to increase the chance that your child will be accepted.
*The YFEHS program is open to all eligible persons, regardless of race, color, national origin, disability, familial status, sex, religion, creed, marital status, age, sexual orientation, or gender identity.
Application Received:
Date:

By:

Applicant & Family Member Information

Applica	ant							RET T	
First		Middle	Last	Suffix	Nicknar	me Bir	thday Gend	der SS	SN Alt ID
Race				Hispanic	English Pro	ficiency	Other Language		Other Language Proficiency
☐ Asian ☐ Black		ican Indian/Alaska		☐ Yes	☐ Little				☐ Little
□ White	□ ⊓awa	iian/Pacific Island Racial	ei	□ No	☐ Moderate☐ None	;			☐ Moderate☐ None
Other:	□ Multi-	Itaciai			☐ Proficien	ł			☐ Proficient
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						Medicaid			
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Race				Hispanic	English Prof	ficiency	Other Language		Other Language Proficiency
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☐ Bacheld ☐ Col Deg		☐ Grade 11 ☐ Grade 12	☐ Part Tim	1	e & Training	☐ Grandc☐ Other F		□ No	☐ Provides Financial Support☐ Teen Parent
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		ther Adult Middle	_ast	Suffix	Nicknan	ne Birt	hday Gend	er SS	N Alt ID
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^{*} If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.

		This Section for A	igency Use Only:		
App	plicant Name: _		Birthday		
2	ZIP	City	State County		

Family Information. Income & Contacts

	mily Informa mily Living Addre				AST AND DE	See Section	EVEN O			
	rted Living At Dat		ess	Address	s Line 2	ZIP	City		State Co	ounty
	mily Mailing Addı me as living?	Started Using Date	Mailing A	Address		Address Line 2	ZIP	City		State
Π,	∕es □ No									
Ph	one Number(s) +	name	Type (che	eck one)		Note (extension	or best time to	call) (Opt In for Tex	t Messages
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			□ Cell □	☐ Home ☐ Worl	k □ Other			1	□ Yes □ No	ſ
			□ Cell □	☐ Home ☐ Worl	k □ Other				□ Yes □ No	
	Parental Status (check one)		Language lome	Homeless Family	Active Duty Military	Military Veteran	Referred Welfare	by Child Agency	Receivin SNAP	g WIC
	One			□Yes	☐ Yes	□ Yes			□ Yes	□ Yes
	Two			□ No	□ No	□ No		No	□ No	□ No
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Birth and Early Childhood Histo	ory:	
Were there any complications or diff	ficulties with the pregnancy: \Box	Yes □ No
If yes, please explain:		
J /1	,	
Did your child need any special medi	ical help at birth? 🗆 Yes 🗆 No	
If yes, please explain:		
J / I		
Was your child premature? ☐ Yes	□ No How many weeks?	
Did your child have any birth defects	-	
If yes, please explain:		
ii yes, piease expiani.		
Child's Developmental History:		
Do you have any concerns about your	r child's development? \(\subseteq \text{Ves} \)	\sqcap No
If yes, which area of development?	remas acveropment.	
□ Overall Development	□ Vision	
☐ Health	☐ Speech/Language	
	☐ Behavior	
☐ Hearing	☐ Benavior	
□ Other:		
Does your child have any disabilities	that have been diagraged by a	physician or apocialist?
	that have been diagnosed by a	mysician or specianst:
☐ Yes ☐ No		
If yes, please explain:		
II1.:1.1	h - 6-11ii2	
Has your child ever received any of the	_	
☐ Early Childhood Intervention (ECI)		☐ Speech Therapy
\square Support and Techniques for Empove	wering People (STEP)	☐ Physical Therapy
□ Occupational Therapy		□ Other:
If yes, please explain:		
Has your child had any extensive hea		
When:	Where:	
By:	Why:	
Does your child have an IFSP (Individ	lual Family Service Plan)?	
□ Yes □ No		
* If yes, our program will need a cop	ov of the plan.	



Application for Enrollment

Were you referred to the program by a child welfare agency? \Box Yes \Box No



Application for Enrollment

If you answer YES to any of the following questions, please explain.

1. Has your child, any other family member or household member been di	iagnosed with a mental
illness? □ Yes □ No	
Explain:	
2. Have there been any major changes in you or your child's life in the last	six months?
□ Yes □ No	
Explain:	
Explain:	custody concerns, etc.?
□ Yes □ No	
Explain:	
4. Is there a family history of substance abuse or domestic violence?	
□ Yes □ No	
Explain:	
□ Yes □ No	
6. Do you or your family need assistance with community resources?	
□ Yes □ No	
Explain:	
7. Please list any community resources you currently work with: [Medical	d, Housing, WIC, SNAP,
etc.).	
□ Yes □ No	
Explain:	
□ Yes □ No	
9. Do either parent have a documented disability?	
□ Yes □ No	
Explain:	
CERTIFICATION: I have carefully reviewed the documents and inform and I certify that this information is true and correct. If any part is fal this agency's programs may be terminated. I also understand that the application will be held in strict confidence with the agency.	se, my participation in
Child's Name	Date of Birth
Parent/Guardian Signature	Date
Staff Signature *This institution (Young Families Early Head Start) is an equal op	Date pportunity provider



Application for Enrollment

Self-Identification for Homeless and Mobile Families

Please answer the question below, indicating what best describes your living situation. The purpose of this information is to ensure the rights of your children and youth under the McKinney Vento law.

Do you or your family live in any of these situations? (Check all that a	pply)
 □ In a shelter (family shelter, domestic violence, youth, or temporary □ In a motel, hotel, or weekly rate housing □ Double up with friends or relatives because you cannot find or affecting in an abandoned building, other inadequate accommodation or in an interpolation or in the street □ In temporary foster care placement (including kinship placement) □ Lack a regular, fixed, or adequate nighttime residence □ With friends or relatives because you are a youth without the accongular guardians 	ord housing a car
$\hfill \square$ Yes, I/we are currently living in one of these situations. A staff mer what \hfill rights we have.	nber should talk to us about
□ Not applicable	
Child's Name	Date of Birth
Parent/Guardian Signature	Date
Staff Signature	Date



Written Statement

Please provide a Written Statement about your living situ information regarding how you, your child and/or your f services.	uation, housing, income, or other pertinent amily would benefit from our program's
Signature	 Date