FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

EARLY CHILDHOOD LEARNING CENTER

AGES 6 WEEKS TO 3 YEARS

2025-2026

Please complete **ALL** forms included in this packet. ***Bring this packet & the following items to Friendship House to complete registration:***

1. **For new applicants:** Complete Online Registration **www.friendshipmt.org**
2. **For returning applicants:** Bill paid in full from previous enrollment
3. Enrolled with Express Pay Online
4. The following items brought to Friendship House:
   a. Registration fee of $30 per family, **must be paid before starting.**
   b. This packet, **fully completed**
   c. A copy of your child's **current immunizations** (you can have them faxed to 406-545-4901)
   d. Copy of your child's **insurance/Medicaid card**

Packets will NOT be accepted by the Front Office until the entire packet is completed and accompanied documents are turned in. Enrollment is on a first come, first served basis.

Friendship House of Christian Service

3123 8th Ave South Billings, MT 59101 (406) 259-5569

Referred by _____

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

ECLC PROGRAM
2025-2026 SCHOOL YEAR
ENROLLMENT INFO
REGISTRATION FORMS

Child's First Name:_____ Child's Last Name:_____

Gender: ☐ MALE ☐ FEMALE Date of Birth:___/___/___

Race/Ethnicity (choose all that apply):

☐ Caucasian
☐ Native American
☐ Asian
☐ African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ Mixed Ethnicity

Has any relation to your child ever been in the military? If so, what relation(s)?

☐Mother ☐Father ☐Grandparent ☐Sibling ☐Aunt/Uncle

How old is your child? (Must be between 6 weeks - 3 years old)

Age:_____

Siblings attending Friendship House Preschool or Youth Program?

Name: _____ Name: _____
Name: _____ NName: _____

Does your child have any disabilities or special needs Friendship House staff should be aware of?

_____

_____

_____

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

IMMUNIZATION REQUIREMENTS

Friendship House is a Licensed Child Care Center through the State of Montana. Children that do not have proof of current immunizations will not be enrolled at Friendship House.

The State of Montana states: Before a child may attend a Montana day care facility, that facility must be provided with the documentation showing that the child has been immunized as required for the child's age group against measles, rubella, mumps, poliomyelitis, diphtheria, pertussis (whooping cough), tetanus, varicella, hepatitis B, pneumococcal, and Haemophilus influenza type B.

Vaccines	**# of Doses**
DTaP	4 doses
Hepatitis B	3 doses
Hib	3-4 doses (depending on vaccine type)
Polio	3 doses
PCV	4 doses (not required after 5 years of age)
MMR	1 dose (2nd by Kindergarten)
Varicella	2 dose (2nd by Kindergarten)

Immunizations are easily obtained by your child's doctor's office or school. You can have them faxed to Friendship House at 406-545-4901

Department of Public Health and Human Services

Early Childhood Services and Family Support Division
Child Care Bureau / Child Care Licensing

NON-INGESTIBLE OVER THE COUNTER MEDICATION AUTHORIZATION FORM

INSTRUCTIONS

PARENT

Please select all non-ingestible over the counter medications, listed below, that you are giving your child care provider permission to administer to your child.

On the line after the medication please indicate if there are special handling or storage instructions, including if the medication needs to be refrigerated.

***This document must be updated on an annual basis.**

PROVIDER

To administer a non-ingestible over the counter medication:

- The medication must
  - include the child's name on the original container
  - be brought to the child care facility by the parent.
  - be in its original container,
  - have a legible label,
  - include the medicines expiration date

***Keep in the child's file when medication is finished.**

Child and Provider Information

Child's Name: _____ Date of Birth: _____

Program Name: _____

Medication Information

Mark all the below listed non-ingestible OTC (over the counter) medications that you are giving the provider permission to administer.

	Special handling/storage Instructions	*Refrigeration?*
☐ Antibiotic Creams/Ointments	_____	☐ Yes ☐ No
☐ Antiseptic *(Iodine, Alcohol, Hydrogen Peroxide)*	_____	☐ Yes ☐ No
☐ Burn Creams/Sprays	_____	☐ Yes ☐ No
☐ Cortisone/Anti-Itch Creams/Ointment	_____	☐ Yes ☐ No
☐ Diaper Rash Cream/Ointments	_____	☐ Yes ☐ No
☐ Insect Repellent	_____	☐ Yes ☐ No
☐ Medicated Lip Treatments	_____	☐ Yes ☐ No
☐ Sunscreen *(see 37.96.506 FIRST AID 2a)*	_____	☐ Yes ☐ No
☐ Other non-ingestible OTC's: *(please specify)*	_____	☐ Yes ☐ No

Parent Signature

I give permission for the administration of the above indicated non-ingestible over the counter medications

Parent/Guardian Signature: *(required)*_____ Date: _____

Unused Medication

Was the unused medication:

- Returned to the parent? ☐ Yes ☐ No By: _____ Date: _____
- Discarded appropriately? ☐ Yes ☐ No By: _____ Date: _____

DPHHS CCL 113 Revision
Date: June 2023

Emergency Contact and Consent

This form must accompany staff when children are away from the childcare site

Child's Name (First, Last)	
Date of Birth	

ALLERGY ALERT **Does your child have allergies? ☐ YES ☐ NO If yes, list all allergies in required box.**

Parent or Guardian Contact Information

Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Primary Phone	Email Address	
Address (Street, City, Zip)		Work Phone

Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child

Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship

Required Medical Information

Primary Medical Care Provider	Phone
Health Concerns (Please explain)	
Allergies	

Parent or Guardian Authorization

In an emergency, the child care facility has my permission to provide or obtain emergency medical treatment including transporting child by ambulance or vehicle if necessary. The parent/guardian of the child will be notified as soon as possible.

Parent/Guardian Signature **Date**

(This form must be completed and signed annually)

Child and Adult Care Food Program (CACFP) Enrollment Income Eligibility Application (EIEA)

PART 1 – CHILDREN'S INFORMATION (REQUIRED)

Child's Name	Birthdate	Age	Check Days of Attendance	Arrival Time	Departure Time	Check Meals and Snacks Normally Received	Check Below if Foster Child
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐
			☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat			☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Eve. Snack	☐

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR IN WA STATE - Any household member receiving benefits can establish eligibility for children in the household. If you list a case number or ID, please skip to part 5.

Case Number or ID number:

PART 3 – TOTAL HOUSEHOLD GROSS ANNUAL INCOME

The adult signing the form must list the last four digits of their Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement and Sources of Income on the back of this page*

***(Annual Income Conversion by pay frequency:* Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12)**

List names (First and Last) of people in your household	Check if no income	Annual Earnings from Work Before Deductions	Annual Welfare, Alimony, Child Support	Retirement, Pensions, Social Security, Other
1.	☐	$ /yr	$ /yr	$ /yr
2.	☐	$ /yr	$ /yr	$ /yr
3.	☐	$ /yr	$ /yr	$ /yr
4.	☐	$ /yr	$ /yr	$ /yr
5.	☐	$ /yr	$ /yr	$ /yr

☐ **I Decline to provide information about my household size and income.**

Number of total Household Members ______ Last 4 of SSN **(check box if no SSN)** ☐

PART 4 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information helps to make sure we are fully serving our community. Responding to this section is optional, it will not affect your children's eligibility for receiving meals during care.

Ethnicity (check one):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (check one or more):
- ☐ American Indian or Alaskan Native
- ☐ Multi-Racial
- ☐ Native Hawaiian or Pacific Island
- ☐ Black or African American
- ☐ Asian
- ☐ White

PART 5 – PARENT/GUARDIAN SIGNATURE AND CERTIFICATION—(REQUIRED) SIGNATURE CONFIRMS ALL INFORMATION PROVIDED IS CORRECT AND ACCURATE

"I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature ______________________ Print Name ______________________ Date ______________

Address: City, State, Zip: Phone Number:

DO NOT FILL OUT – CENTER USE ONLY	CATEGORY		MT CACFP USE ONLY
______________________ Institution Representative Signature ______________ Date **INVALID WITHOUT SIGNATURE AND DATE** (see back for effective date requirements)	☐ Free (Basic Food/TANF/FDPIR) ☐ Free (foster child(ren)	Total Annual Income $____________ ☐ Free ☐ Reduced ☐ Paid	☐ Free ☐ Reduced ☐ Paid ______________ MT CACFP Rep.

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your childcare center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your childcare center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

****EIEA Effective Date****

***If the institution uses the parent/guardian signature date as the effective date, the form must be signed by the institution representative within the same month as the parent, or the following month. If the institution representative does not sign the EIEA within these timeframes, the institution representative's signature date must be used as the effective date.**

Valid TANF or Basic Food Number Guidelines and Contact Resources for MT State Recipients

Consists of six to seven digits, such as 4235555 Does not include any letters Is not a social security number (unless it's a tribal case number)	Does not start with a 200 series number Is not a case number for state-paid childcare Is not an EBT card number
MT DPHHS Public Assistance Customer Service Number: (888) 706-1535	**Basic Food and TANF website: www.apply.mt.gov**

Earnings from Work	Public Assistance, Alimony, Child Support	Pension, Retirement, Other Sources of Income	Sources of Child Income	Examples:
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) If you are in the U.S. Military: • Basic pay and cash bonuses (do **NOT** include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers' compensation • Supplemental Security Income • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans' benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or Disability Benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	Earnings from work	A child of legal working age has a regular full or part-time job where they earn a salary or wages
			Social Security -Disability Payments -Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
			Income from any other source	A child receives regular income from a private pension fund, annuity, or trust

FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

Payment Agreement Form ECLC 2025

Friendship House administrative reimbursement fee invoices are printed at the beginning of every month. Responsible payers must make sure monies are available for your chosen pull date from the 6th-26th of the month. Failure to pay or make arrangements before your pull date will result in a 10% Late Payment Fee. If an arrangement has not been made, your child(ren) will be exited from the program.

We require that students attend Friendship House programs **a minimum of four days a week and at least two hours a day**. We require that you notify the Friendship House Front Office if your child will be absent by 10AM on the day of absence. Failure to inform FH of your child's absence will result in a No Call No Show (NCNS) charge of $5.00 per day per child charge on your account. These charges will be posted and charges pulled within 48hrs. Late pick up (after 5:30PM) will result in $10 per child charge that must be paid before the child returns to our care.

Friendship House has a $30.00 Non-refundable REGISTRATION fee per family. This MUST be paid at time of registration.

All Co-Pays for the Family Connections Best Beginnings Scholarship must be paid in full by the last day of the month. Failure to do so will result in closure of your Best Beginnings Scholarship. You will also be charged the State Daycare Rates to cover our administrative reimbursement fee for that month (which is significantly higher than Best Beginnings Scholarship Co-Pay). If your Best Beginnings Scholarship ends, your account will be charged State Daycare Rates.

Please list your children who are enrolled with Friendship House.

_____ _____ _____ _____

_____ _____ _____ _____

- $638.00 (0-25hrs/week) or $1276.00 (over 25hrs/week) per child are the monthly State Rates for infants and toddlers in the ECLC. $605.00(0-25 hrs/week) or $1210.00 (over 25 hrs/week) monthly State Childcare Rates for children in Preschool. $550.00 a month for less than 25hrs/week, $1100.00 a month for more than 25hrs/ week for children in the Youth program. *These rates are subject to change in accordance with changing State of Montana childcare rates.*
- **Best Beginnings Scholarship through Family Connections.**
  Please inform Best Beginnings that your infant/toddler child is attending **PV 110704 ECLC** Otherwise, full rates will apply.
  Please provide your Family Connections Case Manager Name: _____
- **Friendship House Scholarship**(must apply & qualify)$ _____per month.
  Recipients will be responsible for _____ hours per child in program of either volunteer service hours or attending adult education classes at Friendship House.

By signing below, I acknowledge that I am responsible for paying monthly tuition to Friendship House and abide by the terms listed above. I understand that if I do not make my payment, my child will be exited from the program.

Payer Signature:_____ Date: _____
Payer Name Printed: _____
FH Admin Signature: _____ Date: _____

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT or CREDIT CARD

I (we) hereby authorize (business name) FRIENDSHIP HOUSE OF CHRISTIAN SERVICE to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

CHOOSE A PULL DATE FROM THE 6TH OF THE MONTH TO THE 26TH_____

COMPLETE ONE SECTION ONLY

DO NOT USE DEBIT CARDS.
IF YOU DON'T HAVE CHECKS, PLEASE GET ROUTING NUMBER AND ACCOUNT NUMBER FROM YOUR BANK AND COMPLETE THE ACCOUNT SECTION BELOW.

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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FRIENDSHIP HOUSE
OF CHRISTIAN SERVICE

Scholarship Application

Application is for: ☐ *Summer* ☐ *School Year* ☐ *Preschool*

3 REQUIRED ATTACHMENTS
Application will not be considered unless copies of all documents are attached.

1. **TWO (2) most recent pay stubs for ALL household members**
2. **Most recent federal tax return filed for ALL household members** (please redact Social Security Number prior to submitting)
3. **Best Beginnings denial letter**

FRIENDSHIP HOUSE SCHOLARSHIP PARENT REQUIREMENT: All parents are required to volunteer 1-hour per month (per child) or attend 1-hour of adult education programming per month (per child).

Name: _____ **Phone:** _____

Child(ren):

NAME	AGE	RELATIONSHIP TO YOU

How many people live in your household? _____ **For each occupant of your household, provide name, relationship (to you), gross amount of income (with income frequency):**

NAME	RELATIONSHIP TO YOU	GROSS INCOME	INCOME FREQUENCY

How long have you been with Friendship House? _____

Friendship House Scholarship Application

Please explain why your family needs a Friendship House Scholarship:

Friendship House's extensive programming is heavily supported by community donors, grantors, and partners. Actual costs exceed $1,000.00 per month per child. Your monthly payment amount covers only a portion of this expense. Every family attending Friendship House already receives a substantial scholarship.

The state's Best Beginnings calculation formulas will be used to determine your monthly payment amount.

FALSE STATEMENTS, MISREPRESENTATION, AND FRAUD

Friendship House of Christian Service reserves the right to terminate an application, and/or revoke an awarded scholarship on the basis of false statements, misrepresentations, or other fraudulent declarations provided in this application regarding a level of financial need with the purpose of attaining a Friendship House Scholarship. It also reserves the right to take additional steps as deemed appropriate in instances where a scholarship has been awarded on the basis of misleading or fraudulent information.

By affixing my signature below, I CERTIFY the following:

1. **The information I provided in this application is true and accurate.**
2. **I understand that if any information within this application is found to be untruthful, incomplete, or inaccurate, the application will be considered null and void.**
3. **I understand that scholarship amounts are based on the donations Friendship House receives; thus awards will be granted permitted by available funding.**
4. **I understand that completing this application does not guarantee or entitle me to a Friendship House Scholarship.**

Printed Name: _____ **Signature:** _____

Date Signed: _____