Head Start/ Early Head Start Program

APPLICATION

☐ Hillsborough County BOCC (Head Start/Early Head Start)
3402 North 22nd Street - Tampa, FL. 33605 (813)272-5140

☐ Hillsborough County Public Schools (Head Start)
4350 E. Ellicott Street - Tampa, FL. 33610 (813)740-7870

☐ YMCA (Early Head Start) / FCCH
110 E. Oak Ave.– Tampa, FL. 33602 (813)224-9622

☐ Lutheran Services Florida (Early Head Start)
3615 W. Waters Ave.- Tampa, FL 33614 (813)877-9303

I would like to apply for: Head Start Early Head Start

Application Date: Enroll Date:

CHILD'S INFORMATION

School/Center/Provider	FCCH Site# / Classroom#		
Child's Legal Name (Last)	(First)	Date of Birth	Sex Male Female
E-mail Address	Language Spoken at Home: English Spanish Creole Other _____ Interpreter needed: Yes No Race: Black White Amer. Indian Native Amer. Asian/Pac. Pacific Islander Ethnicity: Hispanic Non Hispanic Other _____		

FAMILY INFORMATION

First and Last Name	Date of Birth	Race/Ethnicity	Sex	Last Grade Completed	EDUCATION (check all that apply) GED	DIPLOMA	AA	BA	Advance Degree
Mother			M F						
Father			M F						
Legal Guardian Relationship to Child: (Check One) ___Foster ___Aunt ___Grandfather ___Grandmother Other _____			M F						

Living Address: City: Zip Code: Apt # Lot # Unit #

Mailing Address: City: Zip Code: Apt # Lot # Unit #

My Living Address is: [ ] My Residence [ ] Living with Relative/Friends [ ] Other _____ Parent Military Deployment Yes No

Mother's Phone #: _____ (Home) / _____ (Cell) / _____ (Other) **Father's Phone #:** _____ (Home) / _____ (Cell) / _____ (Other)

Mother/Guardian Employer's Name: _____ **Work #** _____ **City** _____ **Zip Code** _____

Father/Guardian Employer's Name: _____ **Work #** _____ **City** _____ **Zip Code** _____

Parent Status (in household): One Two Legal Guardian Foster Marital Status: Single Married Divorced Separated Widowed

number of family members you support including yourself: _____ Have you ever had a child in HS/EHS? Yes No

OTHER MEMBERS IN HOUSEHOLD YOU SUPPORT

First and Last Name	Date of Birth	Sex	Relationship to Child	School/Center/FCCH
		M F		
		M F		
		M F		
		M F		
		M F		

EMERGENCY CONTACT INFORMATION (Other than Parent)

Name of Adult	Address	Phone	Relationship

Person(s) Authorized to Pick up Child from the School/Center/Provider

Name of Adult	Address	Phone	Relationship

COMPLETE BOTH SIDES OF APPLICATION

Turn Over →→→

CHILD'S DISABILITIES INFORMATION

Disability Status: Diagnosed Suspected/Concern None Please provide documentation: IEP IFSP Evaluation/Doctors Note

Do you have any concerns regarding your child: Vision Developmental Hearing Speech Other_____

CHILD'S MEDICAL INFORMATION

Medical Diagnosis: _____ Any prescribed medication(s)? Yes No

Diagnosed Asthma Diagnosed Allergies (Food, Insect, Environmental) Other _____

Medical Concern(s) _____ Nutrition Concern(s): Yes No Special Diet: _____

MEDICAID STATUS: Eligible Ineligible Applied Medicaid # _____ HMO Yes No

Medical Insurance: Private KidCare Dental Insurance: Yes No Name:

Was child referred to program by another agency? No Yes (If yes, describe)

Any specific family need or crisis? No Yes (If yes, describe)

PUBLIC ASSISTANCE

NON-CASH			CASH		
FOOD STAMPS	Yes	No	**SSI**	Yes	No
Receiving WIC	Yes	No	**TANF/WAGES**	Yes	No

EMPLOYMENT AND/OR SCHOOL

MOTHER/LEGAL GUARDIAN/RELATIVE CAREGIVER

Employed Yes No **Employed** Full Time Part Time **Paid:** _____Weekly _____Biweekly _____ Monthly

Attends School (Name): _____ Student Status: Full Time Part Time

FATHER/LEGAL GUARDIAN/RELATIVE CAREGIVER

Employed Yes No **Employed** Full Time Part Time **Paid:** _____Weekly _____Biweekly _____ Monthly

Attends School (Name): _____ Student Status: Full Time Part Time

INCOME (DOCUMENTS REQUIRED)

Social Security Benefits $ _____ SSI $ _____ SSD $ _____ Pell Grant $ _____

Unemployment $_____ ____Weekly ____Biweekly ____Monthly Foster Care $ _____

Child Support $ _____ ____Weekly ____Biweekly ____Monthly Other Income _____

PLEASE READ BEFORE SIGNING

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN TO DETERMINE ELIGIBILITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. I UNDERSTAND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL LAWS AND WITHDRAWN FROM THE PROGRAM.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT, THIS PROGRAM DOES NOT DISCRIMINATE BASED ON DISABILITY.

!!! STOP !!!

Family Social Worker: Date Assigned: Date Received by office: Child Plus Data Entry: Clerical:

Do not write in this area -- FOR OFFICE USE ONLY

Sibling Age Eligible Next Year: Yes No Child Age Eligible Next Year: Yes No

	(PTS)	ELIGIBILITY STATUS	(PTS)	
Parental Status:		**Other # 1:**		**Face to Face:** Yes No
Disability Status:		**Other # 2:**		**Telephone:** Yes No
Income:		**Other # 3:**		*Document reason for phone*
Age:		**Other # 4:**		**Total Points:**

Eligibility Comments:

TOTAL EARNED INCOME (Documented)

PREVIOUS 12 MONTHS INCOME
(COMPUTED IN ONE OF THE FOLLOWING WAYS):

1. Mother's Earned Inc. $_____Doc._____
2. Father's Earned Inc. $ _____Doc._____
3. Guardian's Earned Inc. $_____Doc._____

Total Earned Income: $_____

TOTAL OTHER INCOME

TANF $ _____SSI $_____ SSD $_____

Social Security Benefits $ _____

Veteran's Benefits $ _____

Child Support $ _____

Unemployment Compensation $ _____

Other $ _____ Source _____

Total Other Income $_____

Gross Income $_____ **# in Family** _____

CRITERIA ENROLLED UNDER

____A. Age/Income Eligible

____B. Parent Employed, Attending School or Job Training Program

____C. Public Assistance Cash Benefits (TANF & SSI)

____D. Documented Stress in the Home: (Identify)_____

____E. Over Income _____ F. Foster Child

____G. McKinney-Vento _____ H. 101%-130%

101-130% Verification _____

Documents Reviewed and Verified by:_____ **Date:** _____
(Family Service Worker Signature)

Team Leader/Supervisor Signature: _____ **Date:** _____