



## Hillsborough County Head Start/Early Head Start

3639 W. Waters Avenue, Suite 500

Tampa, Florida 33614

(813) 272-5140



### ELIGIBILITY REQUIREMENT INFORMATION SHEET

**Please return this page with your application and documentation!**

Thank you for applying with the Hillsborough County Head Start/Early Head Start Program. In order to determine your child(rens) eligibility, you must provide the items listed below with your application. The completion of this form should not be considered a formal acceptance into the program, but one of the steps in completing the eligibility process.

We accept applications throughout the school year for anyone who is interested in enrolling into the Hillsborough County Head Start/ Early Head Start Program.

**INSTRUCTIONS FOR APPLICATION PROCEDURE – If you need assistance or have questions, please call the number listed above.**

#### **Complete the attached application**

✓ **Attach proof of total household income from all sources to the application.** Please send **COPIES** of the following:

- Birth Certificate
- W-2 or tax return for the previous year
- Last Pay check stubs **or**
- Letter from your employer with income information
- School verification on School Letterhead

**If the following income applies we also need verification.**

- SSI (award letter)
- Cash assistance (TANF) (AFDC award letter)
- Child Support (award letter or copy of checks)
- Veteran's Benefits
- Social Security

**If your address or telephone number changes while waiting to hear from us please call us with the changes.**

# Head Start/ Early Head Start Program

## APPLICATION



- Hillsborough County BOCC (Head Start /Early Head Start)  
3639 W. Waters Ave., Suite 500 Tampa, FL. 33614 (813)272-5140
- Hillsborough County Public Schools (Head Start)  
4350 E. Ellicott Street - Tampa, FL. 33610 (813)740-7870

- YMCA (Early Head Start)  
110 E. Oak Ave. - Tampa, FL. 33602 (813)224-9622
- Lutheran Services Florida (Early Head Start)  
3627 W. Waters Ave. #A-Tampa, FL 33614 (813)877-9303

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

Application Date: \_\_\_\_\_

Enroll Date: \_\_\_\_\_

CHILD'S INFORMATION				Shaded Areas to be completed by Agency Staff	
School/Center	Teacher/Instructor	3 ___ 4 ___ W ___ R ___ EHS ___ VPK ___ TRANSFER ___			
Child's Legal Name (Last)		(First)	Date of Birth	Sex Male Female	
Child's Social Security # (Optional)	Language Spoken at Home: English Spanish Creole Other _____		Interpreter needed: Yes No		
Race: Black White Hispanic Amer. Indian Native Amer. Asian/Pac. Pacific Islander					
Ethnicity: Black White Hispanic Vietnamese Other _____					

FAMILY INFORMATION						
First and Last Name	Date of Birth	Social Security# (optional)	Sex	Last Grade Completed	Hours Worked	Occupation
<b>Mother</b>			M   F			
<b>Father</b>			M   F			
<b>Guardian</b>			M   F			
Relationship to Child: (Check One) ___ Foster ___ Aunt ___ Grandfather ___ Grandmother Other _____						

**Living Address:** \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Apt # \_\_\_\_\_ Lot # \_\_\_\_\_ Unit # \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Apt # \_\_\_\_\_ Lot # \_\_\_\_\_ Unit # \_\_\_\_\_

**My Living Address is:** [ ] My own 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 in Family:** \_\_\_\_\_ **Number of Family Members you Support:** \_\_\_\_\_ **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
		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

Name of Adult	Address	Phone	Relationship

**CHILD'S DISABILITIES INFORMATION**

Disability Status: Diagnosed Suspected/Concern None Please provide documentation: IEP IFSP Evaluation/Doctors Note  
 Does your child have concerns in the following areas: Vision Developmental Hearing Speech Other \_\_\_\_\_

**CHILD'S MEDICAL INFORMATION**

Medical Diagnosis: \_\_\_\_\_ Any prescribed medication(s)? \_\_\_\_\_  
 Diagnosed Asthma Diagnosed Allergies (Food, Insect, Environmental) Other \_\_\_\_\_  
 Medical Concern(s) \_\_\_\_\_ Nutrition Concern(s): Yes No Special Diet: \_\_\_\_\_  
**MEDICAID STATUS:** Eligible Ineligible Applied Former Medicaid # \_\_\_\_\_ HMO Yes No  
 Medical Insurance: Private S-Chip 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** FOOD STAMPS Yes No | **CASH** Are you receiving Child Care Assistance? Yes No  
 Receiving WIC Yes No AFDC/WAGES Yes No SSI/SSD Yes No

**INCOME (BEFORE TAXES AND LIVING IN THE HOME):**

**MOTHER/LEGAL GUARDIAN/RELATIVE CAREGIVER**

Employed Yes No Employed Full Time Part Time Gross Income: \$ \_\_\_\_\_ 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 Gross Income: \$ \_\_\_\_\_ Paid: \_\_\_\_\_ Weekly \_\_\_\_\_ Biweekly \_\_\_\_\_ Monthly  
 Attends School (Name): \_\_\_\_\_ Student Status: Full Time Part Time

**OTHER INCOME (DOCUMENTS REQUIRED)**

Social Security Benefits \$ \_\_\_\_\_ SSI/SSD \$ \_\_\_\_\_ AFDC/WAGES \$ \_\_\_\_\_  
 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.

**PARENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

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)**

<b>Parental Status:</b>		<b>Other # 1:</b>		
<b>Disability Status:</b>		<b>Other # 2:</b>		<b>Acceptance Status:</b>
<b>Income:</b>		<b>Other # 3:</b>		<b>Application Status:</b>
<b>Age:</b>		<b>Other # 4:</b>		<b>Total Points:</b>

Eligibility Comments:

**TOTAL EARNED INCOME (Documented)**

**TOTAL OTHER INCOME**

**CRITERIA ENROLLED UNDER**

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: \$ _____	TANF \$ _____ SSI/SSD \$ _____ Social Security Benefits \$ _____ Veteran's Benefits \$ _____ Child Support \$ _____ Unemployment Compensation \$ _____ Other \$ _____ Source _____ Total Other Income \$ _____	A. Age/Income Eligible B. Parent Employed, Attending School or Job Training Program C. Public Assistance Cash Benefits (AFDC & SSI) D. Documented Stress in the Home: (Identify) _____ E. Over Income _____ G. Foster F. McKinney-Vento _____ H. 101%-130%
<b>Gross Income</b> \$ _____	<b># in Family</b> _____	

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

**Team Leader/Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_