



**Hillsborough County BOCC
Head Start/Early Head Start
3639 W. Waters Ave., Suite 500
Tamp, FL 33614
813-272-5140
Fax # 813-975-2143**



EXPECTANT PARENT PROGRAM

ELIGIBILITY REQUIREMENT:

- 1. Pregnant, preferably 1st pregnancy and in 1st or 2nd trimester.**
- 2. Meet the family income guidelines.**
- 3. By the time when the baby born out of EPP enrolled women is enrolled in Early Head Start Program, Parent must be employed full-time, i.e. > 25 hours a week or in school full-time as verified by the School Program.**

Please return the following documents with the application:

1. Income Documents:
 - a. Individual Income Tax Form 1040 or W2 Form to verify income from last year.
 - b. Proof of receiving any other income, e.g. Social Security, TANF, SSI, Child Support etc.
 - c. If there is no income, notarized Zero Income Statement would need to be completed.
2. Doctor's note or Medical document verifying pregnancy and due date.
3. If employed, a current paystub or employment letter to verify employment.
4. If attending school, a class schedule or school letter to verify school enrollment.

**HEAD START/EARLY HEAD START
EXPECTANT PARENT APPLICATION FORM**

PREGNANT WOMAN'S NAME : _____ **DATE OF BIRTH :** ___/___/___ **RACE:** () BLACK () WHITE () HISPANIC OTHER _____

HOME PHONE # : (____) _____ **ALTERNATE # :** (____) _____ **LANGUAGE SPOKEN AT HOME:** _____ **LAST GRADE COMPLETED:** _____

ADDRESS: _____ **STATE:** _____ **CITY:** _____ **ZIP CODE:** _____

SOCIAL SECURITY# (optional) _____ **MEDICAID:** () YES, MEDICAID#: _____ () NO **OTHER INSURANCE:** () YES, INSURANCE#: _____ () NO

MARITAL STATUS : () SINGLE () SEPARATED () DIVORCED () MARRIED Do you currently have a child in Head Start/Early Head Start? Yes () Name of Center: _____ No ()

NAME	BIRTHDAY	LAST GRADE COMPLETED	SOCIAL SECURITY #(optional)	OCCUPATION	EMPLOYMENT/SCHOOL (NAME/ADDRESS/PHONE)
------	----------	----------------------	-----------------------------	------------	--

EXPECTANT FATHER _____
 FATHER (IF MINOR) _____ MOTHER (IF MINOR) _____
 GUARDIAN _____

OTHERS IN HOUSEHOLD (ADULTS & CHILDREN)				
NAME	RELATIONSHIP	AGE	BIRTHDATE	HEALTH PROBLEMS
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				

EMERGENCY CONTACT INFORMATION			
NAME	ADDRESS	PHONE	RELATIONSHIP
1. _____			
2. _____			

FOR MINORS ONLY

I, _____ (MOTHER/FATHER), GIVE _____
 _____ PERMISSION TO PARTICIPATE IN THE EARLY HEAD START -
 EXPECTANT PARENT PROGRAM.

SIGNATURE OF PARENT _____ DATE _____

PREGNANCY INFORMATION:

Expected Date of Delivery: _____ Is Pregnancy High Risk? Yes () No ()

Are you on bed rest? Yes () No () In your First Trimester (1-3 Months)? Yes () No ()

MEDICAL ALERT INFORMATION (I.E. ALLERGIES, MEDICAL AND/OR DISABLING CONDITINS):

PREFERRED PHYSICIAN'S NAME, ADDRESS AND TELEPHONE NUMBER

PREFERRED HOSPITAL'S NAME, ADDRESS AND TELEPHONE NUMBER

↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓PLEASE COMPLETE OTHER SIDE

GROSS FAMILY INCOME :

1. PREGNANT WOMAN'S WEEKLY INCOME: _____ EMPLOYED SINCE _____

INCOME EARNED IN PREVIOUS 12 MONTHS: \$ _____

SPECIAL NEEDS INFORMATION

ARE YOUR PREGANCY CONSIDERED TO BE A "HIGH RISK"?

2. MOTHER'S (IF MINOR) WEEKLY EARNED INCOME: \$ _____ EMPLOYED SINCE _____
 INCOME EARNED IN PREVIOUS 12 MONTHS: \$ _____

2. FATHER'S (IF MINOR) WEEKLY EARNED INCOME: \$ _____ EMPLOYED SINCE _____
 INCOME EARNED IN PREVIOUS 12 MONTHS: \$ _____

4. OTHER INCOME: NON-CASH: FOOD STAMPS – Yes () No () WIC – Yes () No ()
 CASH AFDC/WAGES - Yes () No () SSI/SSD – Yes () No ()
 CHILD CARE ASSISTANCE- Yes () No ()

SOCIAL SECURITY \$ _____ TANF \$ _____ CHILD SUPPORT \$ _____ OTHER \$ _____

I CERTIFY THAT ALL THE ABOVE 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 TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL LAWS.

 PREGNANT WOMAN'S/PARENT/GUARDIAN'S SIGNATURE DATE

Yes _____ No _____
 HAS THE UNBORN CHILD BEEN DIAGNOSED WITH A SPECIAL CONDITION?
 Yes _____ No _____
 DOCTOR'S NAME: _____
 AGENCY: _____
 ADDRESS: _____
 TELEPHONE: _____
 E-mail Address: _____

DO NOT WRITE BELOW THIS LINE FOR OFFICIAL USE ONLY

Eligibility Status	Points:		Points:	
Parental Status:		Other #1 :		Acceptance Status:
Disability Status:		Other #2:		Application Status:
Income:		Other #3:		Total Points:
Age:		Other #4:		

1. FAMILY SIZE: _____

CRITERIA ENROLLED UNDER: _____ EXPECTANT PARENT PROGRAM

2. GROSS ANNUAL EARNED INCOME (DOCUMENTED):

A. CURRENT EARNED INCOME (COMPUTED IN ONE OF THE FOLLOWING WAYS):

1. MOTHER'S EARNED INCOME \$ _____ DOCUMENTATION: _____

2. FATHER'S EARNED INCOME \$ _____ DOCUMENTATION: _____

B. OTHER INCOME (MONTHLY)

TANF \$ _____ SOCIAL SECURITY BENEFITS \$ _____ VETERAN'S BENEFITS \$ _____ UNEMPLOYMENT COMPENSATION \$ _____
 CHILD SUPPORT \$ _____ OTHERS \$ _____ SOURCE: _____

C. TOTAL GROSS ANNUAL FAMILY INCOME: \$ _____ PAST 12 MONTHS \$ _____ PROJECTED 12 MONTHS \$ _____ INCOME ELIGIBLE () YES () NO OVER INCOME (YES () NO

DOCUMENTS REVIEWED AND VERIFIED BY: _____
 FAMILY SERVICE WORKER'S SIGNATURE

 DATE