

Hillsborough County
 Head Start/Early Head Start
 3639 W. Waters Ave., Ste. 500
 Tampa, Florida 33614
 (813) 272-5140

Head Start/Early Head Start Program

Hillsborough County Public Schools
 Head Start Program
 207 Kelsey Lane, Ste. K
 Tampa, Florida 33619
 (813) 744-8941 ext. 356



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)			Have you ever had a child in HS/EHS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child's Social Security # <i>(Optional)</i>		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		Language Spoken at Home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other _____		
					Language Spoken by Child: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other _____		
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> White-Hispanic <input type="checkbox"/> Black-Hispanic <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Native Amer. <input type="checkbox"/> Asian/Pac. <input type="checkbox"/> Pacific Islander				Ethnicity: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____			
Special Needs Information: Does your child have concerns in the following areas: <input type="checkbox"/> Visual Impairment/Blindness <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Hearing Impairment/Deafness <input type="checkbox"/> Special Diet <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Emotional/Behavioral Disorder <input type="checkbox"/> Learning Disability <input type="checkbox"/> Autism Nutrition Concerns: <input type="checkbox"/> Health Impairment <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Speech/Language Impairment <input type="checkbox"/> Other _____							
FAMILY INFORMATION							
Parent/Legal Guardian Name:			Living Address:				
			City:		Zip Code:		Apt#
							Lot#
							Unit#
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Mailing Address:				
			City:		Zip Code:		Apt#
							Lot#
							Unit#
Name of Employer for Mother/Legal Guardian: _____				Name of Employer for Father/Legal Guardian: _____			
Employer's Address: _____				Employer's Address: _____			
Work Phone #:		City:		Zip Code:		Work Phone #:	
						City:	
						Zip Code:	
Mother's Phone #: _____ / _____ / _____				Father's Phone #: _____ / _____ / _____			
Home Cell Other				Home Cell Other			
Parent Status (in household): <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster			Number in Family: _____		Number in Household _____		Number Children in Family
							Age: 0-3 _____ 4-5 _____
First and Last Name		Date of Birth	Social Security # <i>(Optional)</i>	Sex	Last Grade Completed	Hours worked PER WEEK	Occupation
Mother			- -	M F			
Father			- -	M F			
Guardian			- -	M F			
OTHER MEMBERS IN HOUSEHOLD							
First and Last Name		Date of Birth	Social Security # <i>(Optional)</i>	Sex	Relationship to Child	School/Center	
			- -	M F			
			- -	M F			
			- -	M F			
			- -	M F			
			- -	M F			
EMERGENCY CONTACT & AUTHORIZED PICK-UP INFORMATION							
Name of Adult		Phone		Relationship	Emergency Contact	Authorized Pick-up	
		() -			<input type="checkbox"/>	<input type="checkbox"/>	
		() -			<input type="checkbox"/>	<input type="checkbox"/>	
		() -			<input type="checkbox"/>	<input type="checkbox"/>	
		() -			<input type="checkbox"/>	<input type="checkbox"/>	
COMPLETE BOTH SIDES OF APPLICATION							
Turn Over →→→							

Child's Name: _____ **Date of Birth :** _____

OTHER ELIGIBILITY INFORMATION

NON-CASH		CASH		MEDICAID STATUS: <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible <input type="checkbox"/> Applied <input type="checkbox"/> Former	
FOOD STAMPS <input type="checkbox"/> Yes <input type="checkbox"/> No	AFDC/WAGES <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid # _____	HMO <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Insurance: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> S-CHIP	
Receiving Wic <input type="checkbox"/> Yes <input type="checkbox"/> No	SSI <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Name: _____	

Child has disability or special needs: No Suspected Yes (If yes, give diagnosis, date & source)

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

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

PARENTS INCOME STATUS (BEFORE TAXES AND LIVING IN THE HOME):

MOTHER/LEGAL GUARDIAN/RELATIVE CAREGIVER		FATHER/LEGAL GUARDIAN/RELATIVE CAREGIVER	
Employed Since _____	Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Employed Since _____	Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Gross Income: \$ _____	Gross Year-to-date \$ _____	Gross Income: \$ _____	Gross Year-to-date \$ _____
W2/TAX RETURN \$ _____		W2/TAX RETURN \$ _____	
School Name: _____	Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	School Name: _____	Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

OTHER INCOME (Including Children's Income) (DOCUMENTS REQUIRED)

Social Security Benefits	SSI	AFDC/WAGES	Child Support	Foster Care	Unemployment	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: _____ **E-mail Address:** _____ **DATE:** _____

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

!!! STOP !!!

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

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

ELIGIBILITY STATUS

Child Age Eligible Next Year: Yes No **Brother/Sister Eligible Next Year:** Yes No

Annual Income: \$ _____ **Amount Over:** \$ _____

Center: _____	Center# _____	Other # 1: _____	Acceptance Status: _____
Home Situation: _____		Other # 2: _____	Application Status: _____
Income Points: _____		Other # 3: _____	Disability: _____
Age: _____		Other # 4: _____	Total Points: _____

Eligibility Comments: _____

ANNUAL EARNED INCOME (Documented)	OTHER INCOME:
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<p>PREVIOUS 12 MONTHS INCOME (COMPUTED IN ONE OF THE FOLLOWING WAYS):</p> <p>1. Mother's Earned Income \$ _____ DOCUMENTATION _____</p> <p>2. Father's Earned Income \$ _____ DOCUMENTATION _____</p> <p>3. Guardian's Earned Income \$ _____ DOCUMENTATION _____</p> <p align="right">Total Earned Income: \$ _____</p>	<p>TANF \$ _____ Social Security Benefits \$ _____</p> <p>Veteran's Benefits \$ _____ Child Support \$ _____</p> <p>Unemployment Compensation \$ _____</p> <p>Other \$ _____ Source _____</p> <p>Total Other Income \$ _____</p> <p>Grand Total Income \$ _____ (Other & Earned)</p>
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CRITERIA ENROLLED UNDER:

____ A. Age/Income Eligible ____ B. Parent Employed, Attending School or Job Training Program ____ D. Public Assistance Cash Benefits (AFDC & SSI)

____ C. Documented Stress in the Home: (Identify) _____ ____ E. Over Income

Documents Reviewed and Verified by: _____ **Date:** _____

(Family Service Worker Signature)

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