

# Head Start/ Early Head Start Program

## APPLICATION



**Hillsborough  
County  
Florida**

- Hillsborough County BOCC (Head Start/Early Head Start)  
3402 North 22<sup>nd</sup> 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
<b>Mother</b>			M F					
<b>Father</b>			M F					
<b>Legal 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 Residence [ ] Living with Relative/Friends [ ] Other \_\_\_\_\_ Parent Military Deployment Yes No

**Mother's Phone #:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Father's Phone #:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home      Cell      Other      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** FOOD STAMPS Yes No | **CASH** 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)**

<b>Parental Status:</b>	<b>Other # 1:</b>	<b>Face to Face:</b> Yes No
<b>Disability Status:</b>	<b>Other # 2:</b>	<b>Telephone:</b> Yes No
<b>Income:</b>	<b>Other # 3:</b>	*Document reason for phone*
<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 (TANF & SSI) D. Documented Stress in the Home: (Identify) _____ E. Over Income F. Foster Child G. McKinney-Vento H. 101%-130% 101-130% Verification _____
<b>Gross Income \$</b> _____	<b># in Family</b> _____	

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

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