TAP EARLY HEAD START/HEAD START/HOME BASED/PREGNANT WOMEN'S APPLICATION

Birth and Income verification must be attached to process the application.

Child's Legal Name: LAST: ________________________________ FIRST: ____________________________________

Date of Birth: ____/____/____ Age: ____________ Gender: M F

Early Head Start (6 weeks to 3 years) Center______ Home Based______ Head Start (3 years to 5 years) Center ________ Home Based______

Child's Legal Name: LAST: ________________________________ FIRST: ____________________________________

Date of Birth: ____/____/____ Age: ____________ Gender: M F

Early Head Start (6 weeks to 3 years) Center______ Home Based______ Head Start (3 years to 5 years) Center ________ Home Based________

Child's Legal Name: LAST: ________________________________ FIRST: ____

Date of Birth: ____/____/____ Age: ____________ Gender: M F

Early Head Start (6 weeks to 3 years) Center______ Home Based_______ Head Start (3 years to 5 years) Center________ Home Based_______

Parent(s) Child Lives With: (circle one) O = One parent T = Two parents F = Foster N = Not parent/guardian

Total # of persons: In Family ( ) # of children (18&younger): In Family ( ) How many of the children are: 0-3 ( ) 3-5( )

Mother/Guardian: ______________________________ Date of Birth:____/____/____ Email___________________________
(Or Pregnant Mom's Info)

Street Address: _____________________________________ City: ____________________ State: _______ Zip: _______

Phone: Home ( ) ______ - _________ Phone: Work ( ) ______ - _________ Phone: Message ( ) ______ - _________

School / Company: _____________________________ Address: ____________________________ Hours a week: _____

Father/Guardian: ______________________________ Date of Birth:____/____/____ Email___________________________

Street Address: _____________________________________ City: ____________________ State: _______ Zip: _______

Phone: Home ( ) ______ - _________ Phone: Work ( ) ______ - _________ Phone: Message ( ) ______ - _________

School / Company: _____________________________ Address: ____________________________ Hours a week: _____

Any specific family need or crisis? Y N (If yes, check below)

_____ High Risk (Mental Illness, Disabled adult/sibling, In Treatment, Seriously Ill Child) _____ Living in Public / Low Income Housing

_____ Family Crisis (Terminal Illness, Death, Substance Abuse, Incarcerated) _____ Teen Mom _____ Abuse/Neglect (Child or Parent)

Does child have disability or special need? Y N (If yes, give first name & describe the disability) ____________________________________

If your child is attending any of the following programs please check: ______________________________________

_____ Easter Seals _____ Risk _____ PTOR Professional Therapies

_____ Child Rehab & Development Clinic (CRD) _____ Reach _____ Mental Health Counseling

_____ Roanoke Valley Speech & Hearing _____ Carilion _____ Other ____

Is there a brother/sister already enrolled in Early Head Start or Head Start? Y N (If yes, give first & last name) ________________________

Transition from EHS? Y N

Do you have a center preference? ____

Head Start offers part day for children age 3- 5. Please check here if you are not working / in school or if you want part day hours: 4 hours a day _______ **** Part Day is free**	**Early Head Start & Head Start offer full day.** Please check the hours you need: 8:00am to 4:00pm ONLY_______ Before 8:00am _______ After 4:00pm _______ **** To receive Full Day you must be working or in school 30 hrs a week.** **** There is a fee before 8:00am & after 4:00pm .**

Pregnant Women Only: How long have you been pregnant? _____ Less than 12 weeks _____ 12-24 weeks _____ more than 24 weeks

What is your expected delivery date? _____/_____/_____ Have you received any prenatal care? Provider's Name ________________________

PARENT/GUARDIAN'S SIGNATURE_______________________________________ DATE____________________

TAP Head Start and Early Head Start does not discriminate on the basis of race, color, national origin, sex, disability, or age in programs and activities.

How did you hear about the Head Start program?

TV____ Bus Ad____ Staff____ Friend____ Parade____ Former Parent____ Other Agency____

MAIL APPLICATION TO:
P.O. Box 2868, Roanoke, VA 24001
or
RETURN APPLICATION TO:
108 N. Jefferson St., Suite 302
Roanoke, VA 24016