TAP HEAD START/EARLY HEAD START/HOME BASED APPLICATION

(Alleghany County) *Birth and Income Verification must be attached to process the application*

Child's Legal Name: LAST: _____ FIRST: _____

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

Check One: Early Head Start (6 weeks to 3 years)_____ Head Start (3 years to 5 years)_____

Child's Legal Name: LAST: _____ FIRST: _____

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

Check One: Early Head Start (6 weeks to 3 years)_____ Head Start (3 years to 5 years)_____

Child's Legal Name: LAST: _____ FIRST: _____

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

Check One: Early Head Start (6 weeks to 3 years)_____ Head Start (3 years to 5 years)_____

Parent(s) Child Lives With (circle one): 0 = 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/Pregnant Mom's Name: _____ Date of Birth: ____/___/_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: Home: ( ) _____ - _____ Work: ( ) _____ - _____ Phone: Message ( ) _____ - _____

Email: _____ School/Company: _____ Hours Per Week: _____

Father/Guardian: _____ Date of Birth: ____/___/_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: Home: ( ) _____ - _____ Work: ( ) _____ - _____ Phone: Message ( ) _____ - _____

Email: _____ School/Company: _____ Hours Per Week: _____

Any specific family needs 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, Incarcerate) ____ Teen Mom ____ Abuse/Neglect (Child or Parent)

Does child have a disability or special need?: Y N (If Yes, give first name & describe the disability/need): _____

If your child is receiving services from any of the following programs, please check:

_____ Alleghany Highlands Community Services Board _____ Hazel Lawler Center ____ Social Services

_____ Carillion _____ Jeter Watson Learning Center ____ Speech and Hearing

_____ Child Rehab & Development Clinic _____ Mental Health Counseling ____ Other_____

_____ Easter Seals _____ Safe Homes

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

COMPLETE THIS SECTION FOR CENTER-BASED OPTION ONLY

Early Head Start and Head Start offer full day services from 8:00 a.m. to 4:00 p.m.

**** To receive Full Day you must be working or in school.**

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? Y N Provider's Name: _____

PARENT/GUARDIAN'S SIGNATURE;_____ **DATE:**_____

TAP Head Start and Early Head Start do 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/Early Head Start program?

_____ TV _____ Bus Ad _____ Staff _____ Friend _____ Former Parent _____ Other Agency

MAIL/RETURN APPLICATION TO:
Alleghany Highlands YMCA Central
100 Gleason Avenue
Covington, VA 24426
Phone (540) 862-0488
Fax (540) 862-8675