



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 () _____ - _____
Email: _____ **School/Company:** _____ **Hours Per Week:** _____

Father/Guardian: _____ Date of Birth: ___/___/___ Email _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Phone: Home () _____ - _____ Phone: Work () _____ - _____ Phone: Message () _____ - _____
Email: _____ **School/Company:** _____ **Hours Per 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? _____

<p>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</p>	<p>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. ** There is a fee before 8:00am & after 4:00pm .</p>
--	--

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