



# TAP EARLY HEAD START APPLICATION



(New River Valley) 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 \_\_\_\_\_

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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 \_\_\_\_\_

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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: \_\_\_\_\_

\_\_\_\_ Mental Health Counseling \_\_\_\_ 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

COMMENTS:

**Circle preferred center:**

**Pulaski YMCA**

**Kids & Co**

**Rainbow Riders at St. Michael's**

How did you hear about the Head Start/Early Head Start program?

\_\_\_\_ TV \_\_\_\_ Bus Ad \_\_\_\_ Staff \_\_\_\_ Friend \_\_\_\_ Former Parent \_\_\_\_ Other Agency

**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.*

**MAIL APPLICATION TO:**

**TAP EARLY HEAD START**

**6226 University Park Drive**

**Room 2207**

**Radford, VA 24141**

**F-74 05/18**