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.	**Early Head Start & Head Start offer full day.** Please check the hours you need:
Please check here if you are not working / in school or if you want part day hours: 4 hours a day _____	8:00am to 4:00pm ONLY_____ Before 8:00am _____ After 4:00pm _____
**** Part Day is free**	**** 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