



TAP EARLY HEAD START / HEAD START / 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 Social Security #: _____-_____-_____

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 Social Security #: _____-_____-_____

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 Social Security #: _____-_____-_____

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

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: ___/___/___ Social Security #: _____-_____-_____ (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: ___/___/___ Social Security #: _____-_____-_____

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

COMPLETE THIS SECTION FOR ROANOKE / SALEM CENTER BASED OPTION ONLY

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 _____

Staff use only:

Parental Status _____ Annual Income _____
Disability _____ Income Source _____
Income _____ Income Verification _____
Age _____
Other _____
Total Eligibility Priority Points _____

RETURN APPLICATION TO:

219 Catawba St Glasgow, Va.
MAIL APPLICATION TO:
TAP HEAD START/ Glasgow
P.O. BOX 209
Glasgow, VA. 24555