



# 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 \_\_\_\_\_

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Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: M F

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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? \_\_\_\_\_

<p><b>Head Start offers part day for children age 3- 5.</b>          Please check here if you are not working / in school or if you want part day hours: 4 hours a day _____  <b>** Part Day is free</b></p>	<p><b>Early Head Start &amp; Head Start offer full day. Please check the hours you need:</b>          8:00am to 4:00pm ONLY _____ Before 8:00am _____ After 4:00pm _____  <b>** To receive Full Day you must be working or in school 30 hrs a week.</b>  <b>** There is a fee before 8:00am &amp; after 4:00pm .</b></p>
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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