TAP EARLY HEAD START APPLICATION for Partnerships

Child's Legal Name: LAST: _____ FIRST: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F

Does child have disability or special need? Y N Disability/Need _____

Child's Legal Name: LAST: _____ FIRST: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F

Does child have disability or special need? Y N Disability/Need _____

Child's Legal Name: LAST: _____ FIRST: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F

Does child have disability or special need? Y N Disability/Need _____

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 ( ) # of children ages 0-3 in family ( )

Mother/Guardian: _____ Date of Birth:____/____/____ Email_____

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)

Is your child is attending any of the following programs? Y N (If yes, check below)

_____ Easter Seals _____ Reach _____ Early Intervention

_____ Child Rehab & Development Clinic (CRD) _____ Carilion _____ County/City Preschool

_____ Other _____

Is there a brother/sister already enrolled in Early Head Start? Y N First & Last Name _____

To receive Full Day you must be working or in school 30 hrs a week.

PARENT/GUARDIAN'S SIGNATURE_____ DATE_____

TAP Early Head Start does not discriminate on the basis of race, color, national origin, sex, disability, or age in programs and activities.

TAP EARLY HEAD START
ADMINISTRATION OFFICE
302 2nd STREET, 2nd FLOOR
Roanoke, VA 24011
Phone (540) 283- 4800
Fax (540) 344-3578

RETURN APPLICATION TO:
Rainbow Riders – St. Michael Lutheran Church Site
2308 Merrimac Rd.
Blacksburg, VA 24060
(540) 808-9700 SMLC Site