



**Tri-County Community Council Head Start**  
**2010-2011 Application for Admission**  
2499 Cypress St.  
Westville, FL 32464  
(850) 548-9900

**\*\*Please Complete All Sections of the Attached Application. Use a pen.\*\***  
**APPLICATION MUST BE SIGNED AND DATED**

**Attach the Following Documentation with your Application:**

**#1. Attach proof of your Child's Birth Date.**

**The child's Birth Certificate showing a date of birth on or before September 1, 2007.**

**#2. Attach proof of your Family Income for the Last Calendar Year or the past 12 Months.**

**(A copy of one of the following):**

- **Income Tax Form for the past year completed and signed (1040, 1040A)**
- **W2 Form for the past year**
- **Employer letter stating total gross earnings for the past 12 months**
- **A December pay stub showing the year to date earnings**
- **TANF letter or letter from caseworker**
- **For a child in Foster care, a letter from the caseworker or court documentation**
- **Self declaration statements acceptable under certain conditions**
- **Proof of Residency (copy of driver's license-household bill etc...)**

The following documents will be needed if your child is eligible for enrollment:

**(Do not submit these with this application)**

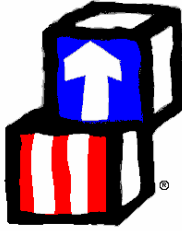
- **Current Immunization Record**
- **Copy of Preschool Physical**
- **Copy of Medicaid or Insurance Card**
- **Parent photo identification**
- **Proof of guardianship, if applicable**

If your child is determined to be eligible you will be notified by letter and asked to fill out an enrollment packet. Once you have completed the enrollment packet and provided copies of the school physical, immunization record and insurance information, you will be notified of acceptance to Head Start and will be given the start date. Before the program year begins an orientation and open house will be given at the center. We ask that all families entering the Head Start program attend.

Received By: \_\_\_\_\_ Date: \_\_\_\_\_

Center(s) Applied For: \_\_\_\_\_

- **Children with disabilities who meet all other requirements are considered for enrollment.**
- **Before the program year begins an orientation and open house will be given at the center. We ask that all families entering the Head Start program attend.**



**Tri-County Community Council Head Start  
2010-2011 Application for Enrollment**

2499 Cypress St.  
Westville, FL 32464  
(850) 548-9900

**Section 1: Child Information: (Fill out one application for EACH child applying)**

1. \_\_\_\_\_  
Child's **Last Name**                                      Child's **First Name**                                      Child's **Middle Name**
2. Ethnic Origin: \_\_\_ African American/Black    \_\_\_ Alaskan Native    \_\_\_ Asian    \_\_\_ Caucasian  
\_\_\_ East Indian    \_\_\_ Native American    \_\_\_ Pacific Islander    \_\_\_ Other \_\_\_\_\_
3. Child's Birth Date: \_\_\_\_\_ Child's Gender: \_\_\_ M \_\_\_ F Child's SS# \_\_\_\_\_
4. Languages Spoken in the Home: Primary \_\_\_\_\_ Secondary: \_\_\_\_\_  
How well does the child speak English: \_\_\_ Very Well    \_\_\_ Not Well    \_\_\_ Not Well    \_\_\_ Not at all
5. Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_
6. Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Message #: \_\_\_\_\_
7. How will your child be cared for outside of Head Start?  
\_\_\_ Extended Care at Head Start                      \_\_\_ Child Care Center (Name: \_\_\_\_\_)  
\_\_\_ Relative or Unrelated Adult                      \_\_\_ Other \_\_\_\_\_
8. Can you transport your child to the center? \_\_\_ Yes \_\_\_ No    Do you own a vehicle? \_\_\_ yes \_\_\_ no

**Section 2: Household Information:**

1. **Number supported by Income:**    Adults \_\_\_                      **Mother is Pregnant** \_\_\_ yes \_\_\_ no  
**Number of Children in the home:**    Children Ages 0-3 \_\_\_                      Ages 4-5 \_\_\_                      Ages 6+ \_\_\_

Family means all persons living in the same household who are: (1) Supported by the income of the parent(s) or guardian(s) of the child enrolling in the program, and (2) related to the parent(s) or guardian(s) by blood, marriage, or adoption. (Ref. Performance Standards part. 1305.2).

2. **Family Receives:**                      \_\_\_ Job/Work Income    \_\_\_ SSI    \_\_\_ Child Support    \_\_\_ TANF  
\_\_\_ Unemployment    \_\_\_ VA    \_\_\_ Military    \_\_\_ Other \_\_\_\_\_

*Please provide the information below for the adult(s) who has/have primary/custodial responsibility for your child:*

**Male Parent/Guardian Information:**

1. Last Name: \_\_\_\_\_
2. First Name/MI: \_\_\_\_\_
3. Birth Date: \_\_\_/\_\_\_/19\_\_\_
4. Indicate relationship to child (Please circle one): Father / Foster/ Grandfather/ Other \_\_\_\_\_
5. Resides in Home: \_\_\_ Yes \_\_\_ No
6. Employment type: \_\_\_ Full Time    \_\_\_ Part Time    \_\_\_ Looking for Work    \_\_\_ Not Looking \_\_\_\_\_
7. Highest Grade Completed: \_\_\_\_\_

**Female Parent/Guardian Information:**

- 1. Last Name: \_\_\_\_\_
- 2. First Name/MI: \_\_\_\_\_
- 3. Birth Date: \_\_\_\_/\_\_\_\_/19\_\_\_\_
- 4. Indicate relationship to child (Please circle one): Mother/Foster/Grandmother/Other \_\_\_\_\_
- 5. Resides in Home: \_\_\_Yes \_\_\_No
- 6. Employment type: \_\_\_Full Time \_\_\_Part Time \_\_\_Looking for Work \_\_\_Not Looking \_\_\_
- 7. Highest Grade Completed: \_\_\_\_\_

**Section 3: Family Composition and Resources**

**Family Type:**

- \_\_\_ Two Parent Family
- \_\_\_ Single parent (mother figure only)      \_\_\_ Foster Family (provide legal documentation)
- \_\_\_ Single parent (father figure only)      \_\_\_ Other family type \_\_\_\_\_
- \_\_\_ Single parent (mother figure only) living with partner
- \_\_\_ Single parent (father figure only) living with partner
- \_\_\_ Teen Parent (currently 18 years old or younger)
- \_\_\_ Other Relative(s) \_\_\_\_\_ (provide legal documentation)

**Number of adults in household:** \_\_\_\_\_ **Number of children in household:** \_\_\_\_\_

Services or financial assistance (Mark all that apply)

- \_\_\_ Medical financial assistance (Medicaid/Medicare)      \_\_\_ Child Support/Alimony
- \_\_\_ Public housing assistance      \_\_\_ Foster Care/Adoption subsidy
- \_\_\_ Food Stamps      \_\_\_ Energy program assistance
- \_\_\_ Public Assistance/Welfare TANF      \_\_\_ SSI (Disability Income)
- \_\_\_ Unemployment      \_\_\_ Child Protective Services
- \_\_\_ WIC      \_\_\_ Other (specify) \_\_\_\_\_

Insurance: \_\_\_\_\_ Private    \_\_\_ Florida Kid Care    \_\_\_ Medicaid    \_\_\_ None    \_\_\_ Other \_\_\_\_\_

**Enrollment priority is given to eligible families who have special needs.  
Please check any circumstances you would like to be considered:**

**Does your child have Special Needs?** \_\_\_Yes \_\_\_No (if yes, mark below where appropriate)  
**Does your child have a current IEP?** \_\_\_Yes \_\_\_No

**Diagnosed** medical or biological issues currently affecting your child (mark all that apply)

- \_\_\_ ADHD/ADD      \_\_\_ Mental Retardation
- \_\_\_ Anemia      \_\_\_ Multiple disabilities including deaf-blind
- \_\_\_ Asthma (requires medication)      \_\_\_ Non-Categorical/Developmental Delay
- \_\_\_ Autism      \_\_\_ Orthopedic Impairment
- \_\_\_ Communication Disorder      \_\_\_ Overweight
- \_\_\_ Diabetes      \_\_\_ Severe Tooth Decay
- \_\_\_ Eczema (requires medication)      \_\_\_ Seizures
- \_\_\_ Emotional/Behavioral Disorder      \_\_\_ Sickle Cell

- |  |  |
|--|--|
| <input type="checkbox"/> Health Impairment_____                | <input type="checkbox"/> Speech/Language Impairment            |
| <input type="checkbox"/> Hearing impairment including deafness | <input type="checkbox"/> Traumatic brain injury                |
| <input type="checkbox"/> Heart Condition                       | <input type="checkbox"/> Visual Impairment including blindness |
| <input type="checkbox"/> High Lead Levels                      | <input type="checkbox"/> Underweight                           |
| <input type="checkbox"/> Learning Disabilities                 | <input type="checkbox"/> Other: _____                          |

**Diagnosed** medical or biological issues currently affecting you, your child, or any of your immediate family members living in the house (mark all that apply)

- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Developmental Disability
- Diabetes
- Mental Illness
- Other: \_\_\_\_\_

**Environmental** issues currently affecting you, your child, or your family (mark all that apply)

- Child Abuse/Neglect
- Family is Homeless (includes families living in temporary shelters, hotels, vehicles, or moving frequently between the homes of family or friends.)
- Transportation
- Parental Substance Abuse
- Domestic Violence
- Incarceration
- Parole/Probation
- Divorce/Separation (in last 24 months)
- Death in the family (in last 24 months)
- You or a family member have been without food in the past month
- Disaster/tragedy/severe trauma/Major family change or crisis

**Other** issues you feel should be considered:

- |   |   |
|---|---|
| <input type="checkbox"/> English as a second language | <input type="checkbox"/> Single parent in school or working         |
| <input type="checkbox"/> Suspected disability_____    | <input type="checkbox"/> Blended Family                             |
| <input type="checkbox"/> Home Safety hazards          | <input type="checkbox"/> Child previously enrolled in Head Start    |
| <input type="checkbox"/> Nutritional needs            | <input type="checkbox"/> Child transferring from another HS Program |
| <input type="checkbox"/> Other _____                  |   |

The information on this form will help us to determine your child's eligibility for Head Start and prioritize your application. **All information supplied will be held in strict confidence.** If you feel uncomfortable filling this portion out and would like to discuss your situation with a Head Start staff member, please call the Family Services Coordinator at 548-9900.

**PLEASE ATTACH PROOF OF INCOME for the last 12 months TO THIS FORM.**

**I certify that the information provided on this application is accurate and truthful to the best of my knowledge, and authorize Head Start to obtain income verification from my employer, if needed.**

_____ <b>Parent/Guardian Signature</b>	_____ <b>Social Security Number</b>	_____ <b>Date</b>
---	--	----------------------

**Has your child previously attended or been on a waiting list for Head Start?**

No  Yes **Where?** \_\_\_\_\_

**Does this child have a sibling that attended or currently attends Head Start?**

No  Yes **When/Where** \_\_\_\_\_ **Name:** \_\_\_\_\_

**How did you hear about Tri-County Head Start? (check all that apply)?**

Radio  Newspaper  Flyer  HS Parent  Walk-in  Other \_\_\_\_\_

Directions to Home: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AGENCY USE ONLY

Child's Name: \_\_\_\_\_

Center(s) Applied for: \_\_\_\_\_

Family Size: \_\_\_\_\_ Income: \_\_\_\_\_ 12 mo \_\_\_\_\_ Cal yr. \_\_\_\_\_ Age 9/1 \_\_\_\_\_

Verifications: Income Statement

- |   |  |
|---|--|
| <input type="checkbox"/> 1040 Tax Statement     | <input type="checkbox"/> Notarized Statement         |
| <input type="checkbox"/> W2 Statement           | <input type="checkbox"/> SSI                         |
| <input type="checkbox"/> Pay Stubs              | <input type="checkbox"/> Child Support               |
| <input type="checkbox"/> Public Assistance form | <input type="checkbox"/> Veterans                    |
| <input type="checkbox"/> Other                  | <input type="checkbox"/> Unemployment/Workman's Comp |

I certify that I have reviewed the income documentation and the above named child has been determined To be:  Income Eligible  Over Income for the 2010-2011 school year.

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_