



## Hillsborough County Head Start/Early Head Start

3639 W. Waters Avenue, Suite 500

Tampa, Florida 33614

(813) 272-5140



### ELIGIBILITY REQUIREMENT INFORMATION SHEET

**Please return this page with your application and documentation!**

Thank you for applying with the Hillsborough County Head Start/Early Head Start Program. In order to determine your child(rens) eligibility, you must provide the items listed below with your application. The completion of this form should not be considered a formal acceptance into the program, but one of the steps in completing the eligibility process.

We accept applications throughout the school year for anyone who is interested in enrolling into the Hillsborough County Head Start/ Early Head Start Program.

**INSTRUCTIONS FOR APPLICATION PROCEDURE – If you need assistance or have questions, please call the number listed above.**

#### **Complete the attached application**

✓ **Attach proof of total household income from all sources to the application.** Please send **COPIES** of the following:

- Birth Certificate
- W-2 or tax return for the previous year
- Last Pay check stubs **or**
- Letter from your employer with income information
- School verification on School Letter Head

**If the following income applies we also need verification.**

- SSI (award letter)
- Cash assistance (TANF) (AFDC award letter)
- Child Support (award letter or copy of checks)
- Veteran's Benefits
- Social Security

**If your address or telephone number changes while waiting to hear from us please call us with the changes.**

# Head Start/ Early Head Start Program

## APPLICATION



- Hillsborough County BOCC (Head Start /Early Head Start)  
3639 W. Waters Ave., Suite 500 Tampa, FL. 33614 (813)272-5140
- Hillsborough County Public Schools (Head Start)  
4350 E. Ellicott Street - Tampa, FL. 33610 (813)740-7870

- YMCA (Early Head Start)  
110 E. Oak Ave.- Tampa, FL. 33602 (813)224-9622
- Lutheran Services Florida (Early Head Start)  
3627 W. Waters Ave. #A-Tampa, FL 33614 (813)877-9303

I would like to apply for:  Head Start  Early Head Start

Application Date:

Enroll Date:

CHILD'S INFORMATION				Shaded Areas to be completed by Agency Staff	
School/Center	Teacher/Instructor	3 ___ 4 ___ W ___ R ___ EHS ___ VPK ___ TRANSFER ___			
Child's Legal Name (Last)		(First)	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child's Social Security # (Optional)	Language Spoken at Home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other _____			Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Native Amer. <input type="checkbox"/> Asian/Pac. <input type="checkbox"/> Pacific Islander					
Ethnicity: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____					

FAMILY INFORMATION						
First and Last Name	Date of Birth	Social Security# (optional)	Sex	Last Grade Completed	Hours Worked	Occupation
<b>Mother</b>			M F			
<b>Father</b>			M F			
<b>Guardian</b>			M F			
Relationship to Child: (Check One) <input type="checkbox"/> Foster <input type="checkbox"/> Aunt <input type="checkbox"/> Grandfather <input type="checkbox"/> Grandmother <input type="checkbox"/> Other _____						

**Living Address:** \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Apt # \_\_\_\_\_ Lot # \_\_\_\_\_ Unit # \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Apt # \_\_\_\_\_ Lot # \_\_\_\_\_ Unit # \_\_\_\_\_

My Living Address is: [  ] My own Residence [  ] Living with Relative/Friends [  ] Other \_\_\_\_\_ Parent Military Deployment  Yes  No

**Mother's Phone #:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Father's Phone #:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Home Cell Other Home Cell Other

**Mother/Guardian Employer's Name:** \_\_\_\_\_ **Work #** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Father/Guardian Employer's Name:** \_\_\_\_\_ **Work #** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

Parent Status (in household):  One  Two  Legal Guardian  Foster **Marital Status:**  Single  Married  Divorced  Separated  Widowed  
 Number in Family: \_\_\_\_\_ Number of Family Members you Support: \_\_\_\_\_ Have you ever had a child in HS/EHS?  Yes  No

OTHER MEMBERS IN HOUSEHOLD YOU SUPPORT				
First and Last Name	Date of Birth	Sex	Relationship to Child	School/Center
		M F		
		M F		
		M F		
		M F		
		M F		

EMERGENCY CONTACT INFORMATION (Other than Parent)			
Name of Adult	Address	Phone	Relationship

Person(s) Authorized to Pick up Child from the School/Center			
Name of Adult	Address	Phone	Relationship

**CHILD'S DISABILITIES INFORMATION**

Disability Status:  Diagnosed  Suspected/Concern  None Please provide documentation:  IEP  IFSP  Evaluation/Doctors Note  
 Does your child have concerns in the following areas:  Vision  Developmental  Hearing  Speech  Other \_\_\_\_\_

**CHILD'S MEDICAL INFORMATION**

Medical Diagnosis: \_\_\_\_\_  Any prescribed medication(s)? \_\_\_\_\_  
 Diagnosed Asthma  Diagnosed Allergies (Food, Insect, Environmental) Other \_\_\_\_\_  
 Medical Concern(s) \_\_\_\_\_ Nutrition Concern(s):  Yes  No Special Diet: \_\_\_\_\_  
**MEDICAID STATUS:**  Eligible  Ineligible  Applied  Former Medicaid # \_\_\_\_\_ HMO  Yes  No  
 Medical Insurance:  Private  S-Chip Dental Insurance:  Yes  No Name: \_\_\_\_\_

**Was child referred to program by another agency?**  No  Yes (If yes, describe)

**Any specific family need or crisis?**  No  Yes (If yes, describe)

**PUBLIC ASSISTANCE**

**NON-CASH** **FOOD STAMPS**  Yes  No **CASH** **Are you receiving Child Care Assistance?**  Yes  No  
 Receiving WIC  Yes  No AFDC/WAGES  Yes  No SSI/SSD  Yes  No

**INCOME (BEFORE TAXES AND LIVING IN THE HOME):****MOTHER/LEGAL GUARDIAN/RELATIVE CAREGIVER**

Employed  Yes  No **Employed**  Full Time  Part Time **Gross Income:** \$ \_\_\_\_\_ **Paid:** \_\_\_\_\_ Weekly \_\_\_\_\_ Biweekly \_\_\_\_\_ Monthly  
 Attends School (Name): \_\_\_\_\_ **Student Status:**  Full Time  Part Time

**FATHER/LEGAL GUARDIAN/RELATIVE CAREGIVER**

Employed  Yes  No **Employed**  Full Time  Part Time **Gross Income:** \$ \_\_\_\_\_ **Paid:** \_\_\_\_\_ Weekly \_\_\_\_\_ Biweekly \_\_\_\_\_ Monthly  
 Attends School (Name): \_\_\_\_\_ **Student Status:**  Full Time  Part Time

**OTHER INCOME (DOCUMENTS REQUIRED)**

Social Security Benefits \$ \_\_\_\_\_ SSI/SSD \$ \_\_\_\_\_ AFDC/WAGES \$ \_\_\_\_\_  
 Unemployment \$ \_\_\_\_\_ Weekly \_\_\_\_\_ Biweekly \_\_\_\_\_ Monthly Foster Care \$ \_\_\_\_\_  
 Child Support \$ \_\_\_\_\_ Weekly \_\_\_\_\_ Biweekly \_\_\_\_\_ Monthly Other Income \_\_\_\_\_

**PLEASE READ BEFORE SIGNING**

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN TO DETERMINE ELIGIBILITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. I UNDERSTAND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL LAWS.

**PARENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT, THIS PROGRAM DOES NOT DISCRIMINATE BASED ON DISABILITY.

**!!! STOP !!!**

Family Social Worker: \_\_\_\_\_ Date Assigned: \_\_\_\_\_ Date Received by office: \_\_\_\_\_ Child Plus Data Entry: \_\_\_\_\_ Clerical: \_\_\_\_\_

**Do not write in this area -- FOR OFFICE USE ONLY**

Sibling Age Eligible Next Year:  Yes  No Child Age Eligible Next Year:  Yes  No

**(PTS) ELIGIBILITY STATUS (PTS)**

<b>Parental Status:</b>		<b>Other # 1:</b>		
<b>Disability Status:</b>		<b>Other # 2:</b>		<b>Acceptance Status:</b>
<b>Income:</b>		<b>Other # 3:</b>		<b>Application Status:</b>
<b>Age:</b>		<b>Other # 4:</b>		<b>Total Points:</b>

Eligibility Comments:

**TOTAL EARNED INCOME (Documented)****TOTAL OTHER INCOME****CRITERIA ENROLLED UNDER**

PREVIOUS 12 MONTHS INCOME  
(COMPUTED IN ONE OF THE FOLLOWING WAYS):

1. Mother's Earned Inc. \$ _____ Doc. _____	TANF \$ _____ SSI/SSD \$ _____	_____ A. Age/Income Eligible
2. Father's Earned Inc. \$ _____ Doc. _____	Social Security Benefits \$ _____	_____ B. Parent Employed, Attending School or Job Training Program
3. Guardian's Earned Inc. \$ _____ Doc. _____	Veteran's Benefits \$ _____	_____ C. Public Assistance Cash Benefits (AFDC & SSI)
	Child Support \$ _____	_____ D. Documented Stress in the Home: (Identify) _____
	Unemployment Compensation \$ _____	_____ E. Over Income _____ G. Foster
	Other \$ _____ Source _____	_____ F. McKinney-Vento _____ H. 101%-130%
Total Earned Income: \$ _____	Total Other Income \$ _____	

**Gross Income \$** \_\_\_\_\_

**# in Family** \_\_\_\_\_

**Documents Reviewed and Verified by:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (Family Service Worker Signature)

**Team Leader/Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_