



**Tri-County Community Council Head Start  
2011-2012 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, 2008.**

**#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.

If your address or telephone number changes while waiting to hear from us please call us with the changes at (850) 548-9900.

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

Center(s) Applied For: \_\_\_\_\_ Pregnant Mom \_\_\_age 0-3 \_\_\_age 3\_\_\_age 4

- **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.**

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

Last	First	Middle	Suffix	Birthdate	Gender	SSN ____-____-____
<b>Ethnic Origin:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> East Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient  Primary <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other Language</b> <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____  Primary <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Doctor</b>		<b>Dentist</b>	
<b>Primary Health Coverage</b>	<b>Other Health Coverage</b>	<b>Insurance #</b>	<b>Medicaid</b> <input type="checkbox"/> not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible		<b>Medicaid #</b>	

**Section 2: Primary Adult**

Last	First	Middle	Suffix	Birthdate	Gender	SSN ____-____-____
<b>Ethnic Origin:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> East Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient  Primary <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other Language</b> <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____  Primary <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Relationship</b>	<b>Highest Grade</b>	<b>Employment</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> Looking for Work <input type="checkbox"/> Not Looking	
<b>Check all that apply</b> <input type="checkbox"/> Lives with family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Custody <input type="checkbox"/> Teen Parent <input type="checkbox"/> If yes Subsidized	<b>Pregnant Mom</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Expected Due Date</b> ____/____/____	<b>Email</b>			

**Secondary Adult**

Last	First	Middle	Suffix	Birthdate	Gender	SSN ____-____-____
<b>Ethnic Origin:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> East Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient  Primary <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other Language</b> <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____  Primary <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Relationship</b>	<b>Highest Grade</b>	<b>Employment</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> Looking for Work <input type="checkbox"/> Not Looking	
<b>Check all that apply</b> <input type="checkbox"/> Lives with family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Custody <input type="checkbox"/> Teen Parent <input type="checkbox"/> If yes Subsidized	<b>Pregnant Mom</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Expected Due Date</b> ____/____/____	<b>Email</b>			

## Other Children in Home

Last	First	Middle	Suffix	Birthday	Gender	SSN - -
<b>Ethnic Origin:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> East Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient  Primary__ Yes __ No	<b>Other Language</b> <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____  Primary__ Yes __ No	Relationship	Highest Grade	Employment	

Last	First	Middle	Suffix	Birthday	Gender	SSN - -
<b>Ethnic Origin:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> East Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient  Primary__ Yes __ No	<b>Other Language</b> <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____  Primary__ Yes __ No	Relationship	Highest Grade	Employment	

Last	First	Middle	Suffix	Birthday	Gender	SSN - -
<b>Ethnic Origin:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> East Indian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____	<b>English Proficiency</b> <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient  Primary__ Yes __ No	<b>Other Language</b> <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____  Primary__ Yes __ No	Relationship	Highest Grade	Employment	

## Family Information

Street Address	City	Zip Code
Mailing Address	City	Zip Code
Phone Number	__ Cell __ Home __ Work __ Other __	
Phone Number	__ Cell __ Home __ Work __ Other __	
Phone Number	__ Cell __ Home __ Work __ Other __	

**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 the home:**

**Children Ages 0-3** \_\_\_\_\_ **Ages 4-5** \_\_\_\_\_ **Ages 6+** \_\_\_\_\_

**. 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

\_\_\_\_\_

Can you transport your child to the center?  Yes  No

Do you own a vehicle?  yes  no

**There is no transportation for Early Head Start**

**Family Income**

**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) \_\_\_\_\_

Provider	Amount	Per (for example: week, bi-week, month, quarter, year)	Verification (for example: W2, Check Stub, TANF, Letter)
	\$		
	\$		
	\$		
	\$		

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

- |  |   |
|--|---|
| <input type="checkbox"/> ADHD/ADD                      | <input type="checkbox"/> Mental Retardation                         |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Multiple disabilities including deaf-blind |
| <input type="checkbox"/> Asthma (requires medication)  | <input type="checkbox"/> Non-Categorical/Developmental Delay        |
| <input type="checkbox"/> Autism                        | <input type="checkbox"/> Orthopedic Impairment                      |
| <input type="checkbox"/> Communication Disorder        | <input type="checkbox"/> Overweight                                 |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Severe Tooth Decay                         |
| <input type="checkbox"/> Eczema (requires medication)  | <input type="checkbox"/> Seizures                                   |
| <input type="checkbox"/> Emotional/Behavioral Disorder | <input type="checkbox"/> Sickle Cell                                |

**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 receive therapy?**  Yes  No

- |  |  |
|--|--|
| <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"/> Other_____                              |
| <input type="checkbox"/> Child transferring from another HS Program |  |

**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:**  
\_\_\_\_\_  
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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.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

## Emergency Contact

<b>Name</b>	<b>Relationship</b>	<b>Emergency Contact</b> ____ Yes ____ No	<b>Release To</b> ____ Yes ____ No
<b>Address</b>	<b>Zip Code</b>	<b>City</b>	<b>State</b>
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		

<b>Name</b>	<b>Relationship</b>	<b>Emergency Contact</b> ____ Yes ____ No	<b>Release To</b> ____ Yes ____ No
<b>Address</b>	<b>Zip Code</b>	<b>City</b>	<b>State</b>
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		

<b>Name</b>	<b>Relationship</b>	<b>Emergency Contact</b> ____ Yes ____ No	<b>Release To</b> ____ Yes ____ No
<b>Address</b>	<b>Zip Code</b>	<b>City</b>	<b>State</b>
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		

<b>Name</b>	<b>Relationship</b>	<b>Emergency Contact</b> ____ Yes ____ No	<b>Release To</b> ____ Yes ____ No
<b>Address</b>	<b>Zip Code</b>	<b>City</b>	<b>State</b>
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		
<b>Phone</b>	____ Cell ____ Work ____ Home		