# TAP EARLY HEAD START APPLICATION

*(**New River Valley**) 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______

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________

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_______

# 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 ( ) ______ - _________

Email: __________________________________________ School/Company: ____________________________________ Hours Per Week: _____

Father/Guardian: ______________________________________ Date of Birth:____/____/____ Email__________________________________

Street Address: ________________________________________________ City: __________________________ State: _______ Zip: _______

Phone: Home ( ) ______ - _________ Phone: Work ( ) ______ - _________ Phone: Message ( ) ______ - _________

Email: __________________________________________ School/Company: ____________________________________ Hours Per 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: ____________________________________

_____ Mental Health Counseling _____ 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

| COMMENTS: | **Circle preferred center:**<br>**Pulaski YMCA – Pulaski VA**<br><br>**Kids & Co – Pearisburg VA**<br><br>**Rainbow Riders at St. Michael's – Blacksburg VA** |
|---|---|

**How did you hear about the Head Start/Early Head Start program?**

**_____ TV _____ Bus Ad _____ Staff _____ Friend _____ Former Parent _____ Other Agency**

**PARENT/GUARDIAN'S SIGNATURE**_________________________________________________ **DATE**_____________________

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

**MAIL APPLICATION TO:**

TAP EARLY HEAD START
6226 University Park Drive
Room 13303
Radford, VA 24141
**Fax**: 540-731-3111
**Phone:** 540-819-0018

**F-74 06/19**