



Application for Early Head Start

Program Options

Please review and select the program options below that apply.

- Services to Pregnant Women** – Services are offered in Leon, Madison and Jefferson Counties. These services include access to comprehensive prenatal and postpartum health care, prenatal education, child development and breastfeeding education.
- Home-Based Program Option** – Services are offered in Leon, Madison and Jefferson Counties. This program option offers comprehensive services in the home, which include education, health, and family services, along with monthly group socializations.
- Center-Based Program Option** – Services are offered in Monticello (Jefferson County), Madison (Madison County) and Tallahassee (Leon County). This program option offers comprehensive services in a classroom setting, which include education, health, and family services, along with family engagement opportunities.

Thank you for your interest in Kids Incorporated Early Head Start (EHS). Our program provides comprehensive services to low-income pregnant women and children, birth through three years of age and their families. Our program partners with families to provide quality early education and care, parenting education, health services, and family support.

Fax: (850) 617-6292
<http://www.kidsincorporated.org>



Revised January 2019

How to Apply

You **MUST** submit all program applications in person at one of the Kids Incorporated of the Big Bend center-based sites (locations are on page 3 of the application). All documentation requested must be attached with the application. Submit by scheduling an appointment or submit during designated walk-in hours. Only a parent or legal guardian may sign this application. Therefore, if you are a relative/guardian caregiver you must provide placement documentation.

- If applying for the Services to Pregnant Women program option, complete pages 4, 6, and 7. Every effort is made to recruit and enroll pregnant women into the program prior to their 22nd week of pregnancy. However, pregnant women are eligible for the program up until the delivery of the child. **You may also contact your local Health Department for services.**
- If applying for the Child Care or Home-Based program option, **skip page 4** and complete pages 5 -7.
- **This is an application to determine eligibility and is not a guarantee of enrollment into the program.** If you need assistance completing this application, please call the center-based site in which you are interesting in applying for.

How is eligibility determined?

Federal regulations require that EHS programs verify the following: pregnancy (if applying for prenatal services), child's age, family income, foster care, homeless, and Part C eligibility. In addition to documentation that support other factors for the specific programs selection criteria.

Attach the following documentation in order for Kids Incorporated to determine eligibility:

- a. Proof of Identity (Driver's License, Passport, Military ID, etc.)
- b. Current residence in the service area (Lease, Utility Bill, Mortgage Statement, etc.)
- c. Proof of Age (birth certificate or hospital documentation proving live birth signed by a hospital official)
- d. Pregnancy Verification
- e. Proof of Income (Pay stubs, Receipt of Child Support, TANF [Cash], SSI, Educational Scholarships and/or Grants, etc.):
 - (1) Paid Weekly – last 6 pay stubs
 - (2) Paid Bi-Weekly – last 3 pay stubs
 - (3) Paid Bi-Monthly – last 3 pay stubs
 - (4) Paid Monthly – last 2 pay stubs
 - (5) New Employment – verification of employment letter from employer
 - (6) Income verification form completed by employer
 - (7) W-2(s) or Income Tax statement or earnings for previous year (*Accepted January – June*)
- f. Insurance Information (Medicaid, Private Insurance, etc.)
- g. Disability/Part C Verification (if applicable):
 - (1) Eligibility Determination
 - (2) Individual Family Service Plan (IFSP)
- h. Foster Care Placement, Adoption, or Legal Guardianship Verification (if applicable)
- i. Homeless Verification (if applicable)
- j. Referral Verification and Proof of Services (Food Stamps, WIC, Florida Kid Care, Subsidized Child Care, etc.)

Head Start definition of income: Income means total cash receipts before taxes (**gross income**) from all sources. Income includes: (1) money, wages or salary before deductions; (2) net income from non-farm or farm self-employment; (3) social security or railroad retirement; (4) unemployment compensation, strike benefits, workers' compensation, veterans benefits, or public assistance; (5) training stipends; (6) alimony, child support, military family allotments, other regular support from absent family member or someone not living in the household; (7) private pensions, government pensions including military retirement, insurance or annuity payments; (8) college scholarships, grants, fellowships, assistantships; (9) dividends, interest, net rental income, net royalties, receipts from estates or trusts; (10) net gambling or lottery winnings.

Center-based program Option

Please select one (1) choice from the list below (Must be working or in school to choose this option):

- | | |
|---|--|
| <input type="checkbox"/> Brandon's Place at Lincoln
438 W Brevard Street
Tallahassee, FL 32301
Hours: 8:00a.m. – 4:00p.m.
(850) 414-9815 | <input type="checkbox"/> Bright Days
250 NW Haynes Street
Madison, FL 32340
Hours: 7:30 a.m. – 3:30 p.m.
(850) 973-4243 |
| <input type="checkbox"/> Budd Bell Early Learning Center
306 Laura Lee Avenue
Tallahassee, FL 32301
Hours: 8:00a.m. – 4:00p.m.
(850) 219-0037 | <input type="checkbox"/> Jefferson County Early Head Start
395 E Washington Street
Monticello, FL 32344
Hours: 8:00 a.m. – 4:00 p.m.
(850) 997-4736 |
| <input type="checkbox"/> Pamela Davis Early Learning Center
1410 Indian Head Drive
Tallahassee, FL 32301
Hours: 8:00 a.m. – 4:00 p.m.
(850) 487-9124 | |

Parents are responsible for transporting their child(ren) to and from the center. Kids Incorporated will ensure that transportation is provided, if needed, for children and/or families to participate and receive other program services (e.g., health screenings, oral health care, Policy Council, other program committees, etc.). For other transportation issues and concerns and/or emergencies, please contact the center's Family Advocate for assistance.

APPLICATION FOR SERVICES

Are you pregnant? Yes No **If yes, when is your due date?** _____.
Please provide copy of your pregnancy statement.

If yes, complete pages 4, 6, and 7.
****If no, complete pages 5 - 7.****

Pregnant Woman's Information

FIRST NAME	MIDDLE	LAST NAME	AGE	DATE OF BIRTH	SEX
LIVING ADDRESS: STREET		APT.	CITY/STATE/ZIP		PHONE #
Email Address: _____					

Race

- American Indian or Alaska Native
 Black or African American
 Native Hawaiian/Other Pacific Islander
 White
 Asian
 Multi-Racial/Bi-Racial
 Other: _____

Hispanic

Yes No

Language

- English Caribbean European/Slavic
 Native Central American/South American
 Other Spanish
 African East Asian Middle Eastern/South Asian
 Native North American/Alaskan Pacific Island

Second Parent/Guardian's Information (Fill out if you are applying for prenatal)

FIRST NAME	MIDDLE	LAST NAME	AGE	DATE OF BIRTH	SEX
LIVING ADDRESS: STREET		APT.	CITY/STATE/ZIP		PHONE #
Email Address: _____					

Race

- American Indian or Alaska Native
 Black or African American
 Native Hawaiian/Other Pacific Islander
 White
 Asian
 Multi-Racial/Bi-Racial
 Other: _____

Hispanic

Yes No

Language

- English Caribbean European/Slavic
 Native Central American/South American
 Other Spanish
 African East Asian Middle Eastern/South Asian
 Native North American/Alaskan Pacific Island

Have you had or do you currently have any of the following? Please check all that apply.

1. <i>C-Section</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	2. <i>Gestational Diabetes or Diabetes</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
3. <i>Living Child with Down Syndrome</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	4. <i>Hypertension (high blood pressure)</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
5. <i>Previous Miscarriage(s)</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	6. <i>Blood Disorder</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
7. <i>Neonatal Death</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	8. <i>Preterm Labor</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
9. <i>Homeless</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	10. <i>Domestic Violence</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
11. <i>Depression or Mental Illness</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	12. <i>Anxiety</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
13. <i>Anemia</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	14. <i>Seizures</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
15. <i>Previous Low Birth Weight Delivery</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	16. <i>Substance Abuse</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current
17. <i>Sickle Cell</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current	18. <i>Multiple Births (twins, triplets, etc.)</i>	<input type="checkbox"/> Past	<input type="checkbox"/> Current

Number of pregnancies including past and current (please check one) 1 2 3 4 5 6 or more

Primary Parent/Guardian's Information (Fill out if you are applying for a child)

FIRST NAME	MIDDLE	LAST NAME	AGE	DATE OF BIRTH	SEX
LIVING ADDRESS: STREET		APT.	CITY/STATE/ZIP		PHONE #

Relationship to Child: _____ Email Address: _____

Race

- American Indian or Alaska Native Black or African American Native Hawaiian/Other Pacific Islander White
 Asian Multi-Racial/Bi-Racial Other: _____

Hispanic Yes No

Language

- English Caribbean European/Slavic Native Central American/South American Other Spanish
 African East Asian Middle Eastern/South Asian Native North American/Alaskan Pacific Island

Second Parent/Guardian's Information (Fill out if you are applying for a child)

FIRST NAME	MIDDLE	LAST NAME	AGE	DATE OF BIRTH	SEX
LIVING ADDRESS: STREET		APT.	CITY/STATE/ZIP		PHONE #

Relationship to Child: _____ Email Address: _____

Race

- American Indian or Alaska Native Black or African American Native Hawaiian/Other Pacific Islander White
 Asian Multi-Racial/Bi-Racial Other: _____

Hispanic Yes No

Language

- English Caribbean European/Slavic Native Central American/South American Other Spanish
 African East Asian Middle Eastern/South Asian Native North American/Alaskan Pacific Island

Applicant Child's Information (Fill out if you are applying for a child)

FIRST NAME	MIDDLE	LAST NAME	AGE	DATE OF BIRTH	SEX
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Race

- American Indian or Alaska Native Black or African American Native Hawaiian/Other Pacific Islander White
 Asian Multi-Racial/Bi-Racial Other

Hispanic Yes No

Language

- English Caribbean European/Slavic Native Central American/South American Other Spanish
 African East Asian Middle Eastern/South Asian Native North American/Alaskan Pacific Island

Please attach a copy of the applicant child's record of birth: birth certificate or hospital document (signed by hospital official).

DISABILITY (Fill out if you are applying for a child)

Is the applicant child currently receiving services from Early Steps? Yes No
Please provide a copy of your child's eligibility determination letter.

HOMELESS

Is the applicant family currently homeless? Yes No
Please provide verification of homelessness.

PARENTAL STATUS (please check one based on number of parents/guardians living in the home)

Foster Parent Relative/Guardian (other than parent) Teen Parent One Parent Two Parents

Is this application for a foster child placed with you through the State of Florida? Yes No

Please provide verification of foster care placement or proof of custody for relative/guardian.

Parent Disability (Physical, hearing, vision or cognitive) Yes No

Please provide proof of parent disability.

OTHER

Have you applied for Subsidized Child Care through the Early Learning Coalition? Yes No

Please provide confirmation.

Are you currently enrolled in the Kids Incorporated EHS prenatal program? Yes No

How many children in the household, including the applicant child, are under the age of 5? _____

Is a sibling currently enrolled in the Kids Incorporated EHS program? Yes No

Do you currently have a child/children enrolled in a **Head Start Program**? Yes No

Please provide proof of Head Start Enrollment.

FAMILY SIZE

In order to determine if your family income is above or below the Federal poverty guidelines, we need to know your family size, as well as your family income. Head Start defines family as "...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."

Please list all family members living in the household that meet the above definition (include child applying).

Name (First, Middle, Last)	Birth Date	Sex	Relationship to Enrolling Child

FAMILY INCOME

Income (**see definition on next page**) must include the total income of the parent/guardian(s) listed above (see Page 2 for instructions).

Are you currently employed? Yes No If yes, are you working Full-time or Part-time?

- If not working, why not? _____

If 2nd parent is living in the household, is he/she currently employed? Yes No If yes, is he/she working

Full-time or Part-time?

- If not working, why not? _____

EDUCATION LEVEL

Are you enrolled in school? Yes No

If 2nd parent is living in household, is he/she enrolled school? Yes No

If yes, what school(s) are you attending? _____

If currently enrolled in school, please provide proof of student status (schedule & financial aid).

What is the highest grade/degree you have completed?

- Less than a High School Diploma
- High School Diploma/GED
- Some College/Advance Training
- Training/Vocational Certification
- Associate's Degree
- Bachelor's Degree
- Master's Degree

If applicable, highest grade/degree 2nd parent has completed?

- Less than a High School Diploma
- High School Diploma/GED
- Some College/Advance Training
- Training/Vocational Certification
- Associate's Degree
- Bachelor's Degree
- Master's Degree

Do you have a referral from one of the following? Please check all that apply.

Please provide proof you have been referred from any of the services listed below.

- Protective Services
- Health Department/Healthy Start
- Children's Home Society/Early Steps
- WORKFORCE
- WIC
- Pregnancy Help Information Center
- Transitional Child Care
- Children's Medical Services
- Other (i.e., Brehon, Hope, etc.)

Are you currently receiving any of the following? Please check all that apply.

Please provide proof you are a current recipient of any of the services listed below.

- Food Stamps
- WIC
- TANF (Cash Assistance)
- Medicaid
- Florida Kid Care
- Subsidized Child Care/School Readiness
- Supplemental Security Income
- Other

Is one of the biological parents of the applicant child or expectant father incarcerated? Yes No

Is one of the biological parents of the applicant child or expectant parent in the U.S. Military? Yes No

OTHER CRITERIA: EHS does not serve on a first come, first serve basis, but on priority as outlined by federal regulations and selection criteria developed and approved for our program. Therefore, additional questions on the application must be answered in order to determine priority. If eligible, you or your child will be placed on the waitlist.

In accordance with Head Start Performance Standards, all information obtained about children and families is confidential. Files are kept in a locked file cabinet and staff access is controlled on a "need to know" basis. Professionals serving on federal and internal review teams are allowed to review files in their capacity as monitors of federal funding. Kids Incorporated does not discriminate against children or families on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation and marital or family status.

I certify that I am the pregnant woman and/or parent or legal guardian of the child applying for EHS, and that to the best of my knowledge all information is correct. I understand that if I deliberately misrepresented this information, my family may not be eligible for services. I authorize EHS to verify this information with any necessary sources.

Parent/Guardian Signature

Date

For Office Use Only [To Be Completed by Center/Site Staff]

Interviewer/Staff's Name: _____ Date of Participant Interview: _____

Date Entered in ChildPlus: _____ Interviewer/Staff's Initials: _____