CAPITAL AREA COMMUNITY ACTION AGENCY, INC.
309 OFFICE PLAZA DRIVE
TALLAHASSEE, FLORIDA 32301
(850) 201-2050
HEAD START CENTERS

Child's Name: _____

CENTER APPLYING FOR: 1st choice:	2nd choice:

Franklin County
Franklin County Head Start
222 6th Street
Apalachicola, Florida 32320
7:30 a.m. – 4:00 p.m.

Jefferson County
Jefferson County Head Start
950 Mamie Scott Drive
Monticello, Florida 32344
7:30 a.m. - 2:00 p.m.

Leon County

Mabry Street Head Start
240 Mabry Street
Tallahassee, Florida 32304
7:30 a.m. - 2:00 p.m.
Extended Day Location Hours: 2:00 – 5:30 p.m.

Louise B. Royal Head Start
1124 North Duval Street
Tallahassee, Florida 32303
7:30 a.m. - 2:00 p.m.
Extended Day Location Hours: 2:00 p.m. – 5:30 p.m.

South City Head Start
2813 South Meridian Street
Tallahassee, Florida 32301
7:30 a.m. - 2:00 p.m.
Extended Day Location Hours: 2:00 – 5:30 p.m.

To qualify, you must be a resident of Leon, Jefferson and Franklin County. Applications will NOT be processed for enrollment until all documentation is provided and verified.

Child must be 3 or 4 years old by September 1 of the year for which you are applying.

1. Child's Birth Certificate or Passport
2. Proof of Guardianship (if your name is not on the Child's Birth Certificate)
3. Valid driver licenses, Student I.D., State Issue I.D.
4. Valid Medicaid number or Insurance Card
5. Verification of all family income of (Parent(s) or Guardian(s) for the past 12 months such as:
   √ Most Current Income Tax form (1040, 1040A, W-2, 1099, etc.)
   √ Check Stubs (12 consecutive months)
   √ SSI, SSA, or Social Security Benefits (current award letter(s))
   √ Proof of residency (current lease and document with same mailing address)
   √ Child Support – total distribution (12 consecutive months)
   √ Unemployment Compensation – current unemployment Letter of Eligibility
   √ TANF (Cash Assistance) – computer printout from the Department of Children & Families
   √ Statement from Employer – on letterhead that includes date of hire, current pay rate, number of work hours per week, total income for the last 12 months, verification signature & date.

Community Action offers an Extended Day Program at the South City and Louise B. Royal and Mabry locations. To be eligible for the Extended Day Program, 3 year olds must be enrolled in School Readiness and 4 year olds must be enrolled in School Readiness and/or Voluntary Pre-Kindergarten (VPK).

Capital Area Community Action Agency, Inc.
Head Start Child Development Program
309 Office Plaza Drive
Tallahassee, Florida 32301

Child's First Name	Child's Middle Name	Child's Last Name	Child's Birthday	Sex	Medicaid #
			/ /	☐ Male ☐ Female	

Race/Ethnicity	Primary Language Spoken	Primary Health Coverage
☐ Asian ☐ Black ☐ White ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other:_____	☐ English ☐ French ☐ Spanish ☐ Haitian Creole ☐ Arabic ☐ Other:_____	☐ Medicaid ☐ Private ☐ Tri-Care ☐ Florida Kidcare (CHIP) ☐ Medicaid/Chip ☐ Other_____

(Parent/Guardian) Lives with Family? ☐ Yes ☐ No **Teen Parent?** ☐ Yes ☐ No

First Name	Last Name	Birthday	Sex	Parental Status
		/ /	☐ Male ☐ Female	☐ Parent ☐ Foster ☐ Legal Guardian

Race/Ethnicity	Primary Language Spoken	Highest Grade Completed
☐ Asian ☐ Black ☐ White ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other:___	☐ English ☐ French ☐ Spanish ☐ Haitian Creole ☐ Arabic ☐ Other:_____	☐ Grade 9 or Below ☐ High School Grad ☐ Grade 10 or 11 ☐ GED ☐ Tech/Trade ☐ Associate Degree ☐ Bachelors ☐ Masters ☐ Some College ☐ Other:_____

Employment Status	Currently Enrolled in School	Child's Relationship to Adult	Custody	Provides Financial Support
☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Unemployed ☐ Retired/Disabled ☐ Other:___	☐ Yes ☐ No ☐ Full-Time ☐ Part-Time	☐ Natural/Adopted ☐ Foster ☐ Grandchild ☐ Niece/Nephew ☐ Other:___	☐ Yes ☐ No	☐ Yes ☐ No

Phone Numbers ☐ Cell# (_____) _____ - _____   ☐ Work# (_____) _____ - _____   ☐ Home# (_____) _____ - _____

Email address:

(Parent/Guardian) Lives with Family? ☐ Yes ☐ No **Teen Parent?** ☐ Yes ☐ No

First Name	Last Name	Birthday	Sex
		/ /	☐ Male ☐ Female

Race/Ethnicity	Primary Language Spoken	Highest Grade Completed
☐ Asian ☐ Black ☐ White ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other:___	☐ English ☐ French ☐ Spanish ☐ Haitian Creole ☐ Arabic ☐ Other:_____	☐ Grade 9 or Below ☐ High School Grad ☐ Grade 10 or 11 ☐ GED ☐ Tech/Trade ☐ Associate Degree ☐ Bachelors ☐ Masters ☐ Some College ☐ Other:_____

Employment Status	Currently Enrolled in School	Child's Relationship to Adult	Custody	Provides Financial Support
☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Unemployed ☐ Retired/Disabled ☐ Other:___	☐ Yes ☐ No ☐ Full-Time ☐ Part-Time	☐ Natural/Adopted ☐ Foster ☐ Grandchild ☐ Niece/Nephew ☐ Other:___	☐ Yes ☐ No	☐ Yes ☐ No

Phone Numbers ☐ Cell# (_____) _____ - _____   ☐ Work# (_____) _____ - _____   ☐ Home# (_____) _____ - _____

Email address:

Is the ☐ mother/ ☐ father of the child incarcerated? ☐ Yes ☐ No

ADDITIONAL Family Members in Household living with child (Do not list Applicant, Parent/Guardian)

First/Last Name	Birthday	Sex	Race	Hispanic	Language	Relationship to Primary Adult
	/ /	☐ F ☐ M		☐ Yes ☐ No		
	/ /	☐ F ☐ M		☐ Yes ☐ No		
	/ /	☐ F ☐ M		☐ Yes ☐ No		

Total Number in Household (please circle)
1 2 3 4 5 6 7 8 9 10 other

Total Number in Family (Count yourself and all family members supported by (parent(s) income) (please circle)
1 2 3 4 5 6 7 8 9 10 other

Living Address	Apt or Lot #	City	State	Zip

Mailing Address (if different)	Apt or Lot #	City	State	Zip

Parent Signature/Guardian's Signature: _____ Date: _____

Family Information

Parental Status (check one)	Marital Status (check one)		Homeless Family	Military Family	Referred by (DCF,Health Dept.etc)	Receiving SNAP (food stamps)	WIC
☐ One ☐ Two	☐ Married ☐ Single	☐ Divorced ☐ Separated	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Is Family a Self-Sufficient Client? ☐ Yes ☐ No   Getting Ahead in a Just-Getting' by World? ☐ Yes ☐ No

ALL Family Income MUST be REPORTED (mark each box)

TANF	Supplemental Security Income (SSI)	Foster Care	Child Support	Social Security (Retirement,Disability,Survivors,Dependent)	Unemployment
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Child's Health Information and Developmental Concerns

Are there any specific family needs or crisis?	☐ Yes ☐ No	(If yes, provide documentation)
Does the child have a medical condition?	☐ Yes ☐ No	(If yes, please list)
Does the child have a disability or special need?	☐ Yes ☐ No ☐ Suspected	(If yes, please describe)
Does the child have a behavioral issue?	☐ Yes ☐ No ☐ Suspected	(If yes, please describe)

Does the child have an Individual Education Plan (IEP or IESP)? (Written document of child's educational needs and goals?)   ☐ Yes ☐ No

Emergency contacts (List other than Adult 1 or Adult 2)

Name (First/Last)	Relationship to Child	Contact Number	Type (Check One)	Emergency Contact?	Release To?
		( ) -	☐ Cell ☐ Home ☐ Work	☐ Yes ☐ No	☐ Yes ☐ No
Name (First/Last)	Relationship to Child	Contact Number	Type (Check One)	Emergency Contact?	Release To?
		( ) -	☐ Cell ☐ Home ☐ Work	☐ Yes ☐ No	☐ Yes ☐ No

CERTIFICATION (I CERTIFY AND UNDERSTAND THE FOLLOWING)

I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian's Signature: **Date:**

School Year:	**Program Code:** H	**Program Desc:** SF	**Delegate ID:** 0000	**Class Age:**
Participation Year: 1 2 3	**Application Status:**	**Application Date:**		**Acceptance Status:**
Center Name: FC, JC, LBR, MB, SC		**Center ID:** 2200, 2207, 2208, 2202, 2209		

Eligibility Information

Child Eligible Next Year?   Yes   No   Brother/Sister Age Eligible Next Year?   Yes   No

Income Status: Eligible   Over   Federal Guideline: Disability Status: Z(Zero Disability)
                                          Family Income: X(Suspected)   D(Diagnosed)

USDA Status: Free   Reduced   None   CACFP Certification Date: USDA Household Income:

Elig-Parent Stat: Pt:	**Elig-Disabled** Pt:	**Elig-Income:** Pt:
Elig-SSI / SSA Pt:	**Elig-FS** Pt:	**Elig-Student** Pt:
Elig-Other: Pt:	**Elig-Age:** Pt:	**TOTAL ELIG RATING:**

Verification Information

Income Verified By? ( ) W-2   ( ) Check Stub   ( ) Tax Return   ( ) Letter   ( ) Notarized Affidavit ( ) Other:_____
( ) Financial Aid   ( ) Income Verification Letter   ( ) SSI/SSA   ( ) Notarized Letter   ( ) Child Support

Birth Verified By?   ( ) Certified Birth Certificate   ( ) Passport   ( ) Hospital Birth Certificate

Income (list by family member) Twice a month x 24 = Annual Income Monthly x 12 = Annual Income				Weekly x 52 = Annual Income Every 2 Weeks x 26 = Annual Income	Income Source
Family Member	Amount	Per	X	Annual Income	From Whom
	$			$	
	$			$	
Total Yearly Income of Family				$	

Processed By: **Date Processed:**

Revised 3/04/2019