

Indicate your county of residence: Charlotte DeSoto Hardee Highlands

Are you currently:

	Parent 1	Parent 2	(ONLY IF IN HOUSEHOLD)
1. Employed and/ or going to school at least 20hrs per week?	Y N	Y N	
2. Disabled?	Y N	Y N	

If either parent/ guardian answered no to both questions, **STOP** you are not eligible at this time.
If both parent/ guardian answered **YES** to at least one of the above, please complete the following application in its entirety.

Primary Language Spoken: _____

Primary Parent/Guardian

Social Security : _____ Last Name: _____ First Name: _____ M: _____
 Date of Birth: _____ Sex: _____ Marital Status: _____
 Race: Hispanic White Black Asian US Indian/Alaskan Hawaiian/Pacific

Secondary Parent/Guardian (ONLY IF IN HOUSEHOLD)

Social Security : _____ Last Name: _____ First Name: _____ M: _____
 Date of Birth: _____ Sex: _____ Marital Status: _____
 Race: Hispanic White Black Asian US Indian/Alaskan Hawaiian/Pacific

Residential Address: _____ **Mailing Address: (If different than Residential Address)** _____
 Address: _____ Address: _____
 City: _____ Zip Code: _____ City: _____ Zip Code: _____
 Phone Number: _____ Alternate Number: _____ E-mail: _____

PLEASE LIST ALL CHILDREN IN THE HOUSEHOLD

First Name: _____ Last Name: _____ Date of Birth: _____
 Relationship of parent to child: Parent/ Step Parent Relative Legal Custodian Other: _____
 Sex: _____ SSN: _____ Are you needing child care assistance for this child? Yes No
 Race: Hispanic White Black Asian US Indian/Alaskan Hawaiian/Pacific

First Name: _____ Last Name: _____ Date of Birth: _____
 Relationship of parent to child: Parent/ Step Parent Relative Legal Custodian Other: _____
 Sex: _____ SSN: _____ Are you needing child care assistance for this child? Yes No
 Race: Hispanic White Black Asian US Indian/Alaskan Hawaiian/Pacific

First Name: _____ Last Name: _____ Date of Birth: _____
 Relationship of parent to child: Parent/ Step Parent Relative Legal Custodian Other: _____
 Sex: _____ SSN: _____ Are you needing child care assistance for this child? Yes No
 Race: Hispanic White Black Asian US Indian/Alaskan Hawaiian/Pacific

First Name: _____ Last Name: _____ Date of Birth: _____
 Relationship of parent to child: Parent/ Step Parent Relative Legal Custodian Other: _____
 Sex: _____ SSN: _____ Are you needing child care assistance for this child? Yes No
 Race: Hispanic White Black Asian US Indian/Alaskan Hawaiian/Pacific

First Name: _____ Last Name: _____ Date of Birth: _____
 Relationship of parent to child: Parent/ Step Parent Relative Legal Custodian Other: _____
 Sex: _____ SSN: _____ Are you needing child care assistance for this child? Yes No
 Race: Hispanic White Black Asian US Indian/Alaskan Hawaiian/Pacific

Please fill out income information on back side of application. Once completed submit application to your local coalition office listed below:



Charlotte Office
3028 Caring Way, Suite 2
Port Charlotte, FL 33952
Phone: (941) 255-1650
Fax: (941) 255-5856

DeSoto Office
4 West Oak Street, Suite H
Arcadia, FL 34266
Phone: (863) 494-5233
Fax: (863) 494-5291

Hardee Office
324 N. 6th Avenue
Wauchula, FL 33873
Phone: (863) 767-1002
Fax: (863) 767-1007

Highlands Office
209 N. Ridgewood Drive
Sebring, FL 33870
Phone: (863) 314-9213
Fax: (863) 314-4480



Household Income Information:

Primary Parent/Guardian			
Employer Name: _____	Number of hours worked per week? _____		
Work Phone: _____	Hourly Rate: _____	If other please specify: _____	
School Name: _____	Credit Hours _____	If other please specify: _____	

Secondary Parent/Guardian (ONLY IF IN HOUSEHOLD)			
Employer Name: _____	Number of hours worked per week? _____		
Work Phone: _____	Hourly Rate: _____	If other please specify: _____	
School Name: _____	Credit Hours _____	If other please specify: _____	

ATTENTION FAMILIES IN WHICH ONE OR BOTH PARENTS ARE ABSENT FROM THE HOUSEHOLD:

If you can not produce current child support documentation through the state Child Support Enforcement Agency for each of the children in your home, you will be required to visit your local office before services may begin.

Please provide amount of income received and frequency (Ex: Weekly, Biweekly, Semi-Monthly, Monthly, etc.)

Please check the following			Amount & Frequency	Name
	Yes	No		
Child Support (Please state if you are receiving or paying child support)				
Alimony				
TANF/ AFDC				
Veteran's Benefits				
Retirement				
Social Security				

Please check the following			Amount & Frequency	Name
	Yes	No		
Relative Care Giver Funds (RCG)				
Unemployment				
Worker's Comp				
Interest/ Dividends				
SSI				
Other				

IMPORTANT NOTE: This **does not** automatically place your child on the wait list for services and **does not** guarantee placement into programs. If you are assessed as eligible based on stated information in this application, you will be placed on Early Learning Coalition of Florida's Heartland, Inc. waiting list. Eligibility is based on income, household size, residence and purpose of care. (Employment/ School attendance- Minimum 25 hours/week for full time child care or 20hours/week for part-time.) When funds become available, you will be contacted for additional information and verification including 6 weeks of pay stubs (please save your pay stubs.)

I certify that the above information is true and correct and that all income is reported. I understand that the information on this form is being given to determine eligibility for a Federal/State program. It may be shared with local public schools early childhood programs, RCMA, FDLRS/Child Find and Early Steps (EIP).

Parent Signature _____
Date

ELCFH Office Use Only

Primary Parent:

Employed _____ hrs

School _____ hrs

Disable

Secondary Parent:

Employed _____ hrs

School _____ hrs

Disable

For Desoto Only:

If 3, 4 or 5 years old mail HIPPIY brochure

Total Annual Gross Income	Family Size	Eligible Category	Date Calculated

ELCFH Staff

Ineligible due to:

Not in County

Doesn't meet guidelines

Incomplete Application

Over Income