

Early Head Start Head Start Pre-K

A selection committee will determine if your child is eligible for Tazewell Co. Pre-K or CVCA Head Start/Early Head Start

**Tazewell County Preschool
Partnership Application**
Return to PO BOX 188, North Tazewell, Virginia
24630
276 988-5583

Child's Name: _____

Parent/Guardian Information

Last	First	Middle	Date of Birth	Social Security #	Sex	Education Level	Employment Status	Race	Live with Family	Financial Support	Teen Parent	Public Assistance
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> TANF <input type="checkbox"/> SSI
Employer's Name:				Contact Person:				Phone:				
Last	First	Middle	Date of Birth	Social Security #	Sex	Education Level	Employment Status	Race	Live with Family	Financial Support	Teen Parent	Public Assistance
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> TANF <input type="checkbox"/> SSI
Employer's Name:				Contact Person:				Phone:				

Children Information

Last	First	Middle	Date of Birth	Social Security #	Sex	Related to Primary Adult	How related	Disabilities	Primary Lang.	Race	Dual Custody
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Family Member Information Living in Home

Last	First	Middle	Date of Birth	Social Security #	Sex	Related to Children	How related	Primary Lang.	Race	Education Level	Employment Status
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Last	First	Middle	Date of Birth	Social Security #	Sex	Related to Children	How related	Primary Lang.	Race	Education Level	Employment Status
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Last	First	Middle	Date of Birth	Social Security #	Sex	Related to Children	How related	Primary Lang.	Race	Education Level	Employment Status
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Previous Child Care/School attended:	Name:	Phone #:	Current Child Care/school attending:	Name:	Phone #:
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Child' Name: _____

Family Information

Mailing Address:				Physical Address:							
City:		State:		Zip:		City:		State:		Zip:	
Phone: ()			<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message			2 Phone: ()			<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message		
# in Family:		# of Children:		# Children by Age:		0 to 4:		4 to 5:		# in Household:	
Family Type:	<input type="checkbox"/> Two Parent Family <input type="checkbox"/> Female Single Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Foster Family <input type="checkbox"/> Female Single Parent living with Partner <input type="checkbox"/> Male Single Parent living with Partner <input type="checkbox"/> Other relative(s) <input type="checkbox"/> Other, Specify:										

Directions to home: _____

Release Child To:	Relationship	DO NOT Release Child To: Must have custody papers if biological parent	Relationship
Name:		Name:	
Name:		Name:	
Name:		Name:	
Name:		Name:	

Emergency Information:		Physician:	Phone:	
Emergency Contact 1:		Physical Address:	Phone:	
		City:	State:	Zip:
Emergency Contact 2:		Physical Address:	Phone:	
		City:	State:	Zip:

Health Coverage:	Primary: <input type="checkbox"/> FAMIS <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None	Secondary: <input type="checkbox"/> FAMIS <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None
Health Insurance/Medicaid Policy #	Secondary Health Insurance Policy #:	

Parent/Guardian report and records indicate no disabilities.

Disabilities	Suspected	Identified	Date	Evaluated by	Disabilities	Suspected	Identified	Date	Evaluated by
Autism	<input type="checkbox"/>	<input type="checkbox"/>			Emotional/behavioral	<input type="checkbox"/>	<input type="checkbox"/>		
Health Impairment	<input type="checkbox"/>	<input type="checkbox"/>			Hearing Impairment/deafness	<input type="checkbox"/>	<input type="checkbox"/>		
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>			Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>		
Multiple Disabilities	<input type="checkbox"/>	<input type="checkbox"/>			Non Categorical/Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>		
Orthopedic Impairment	<input type="checkbox"/>	<input type="checkbox"/>			Speech or language impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>			Visual impairment/blindness	<input type="checkbox"/>	<input type="checkbox"/>		

Type of Services or Financial Services Received:

<input type="checkbox"/> No Services Received	<input type="checkbox"/> Child Support/Alimony	<input type="checkbox"/> Medical Assistance	<input type="checkbox"/> Public Assistance/DSS	<input type="checkbox"/> Energy Assistance Program
<input type="checkbox"/> EPSDT	<input type="checkbox"/> Public Housing Assistance	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Adoption Subsidy
<input type="checkbox"/> Unemployment	<input type="checkbox"/> SSI, Whom:	<input type="checkbox"/> WIC	<input type="checkbox"/> Other	

Child Name: _____

Type of Housing House Apartment Mobile Home Community Shelter Homeless/No Housing Relative/Friend Other:

House Payment Arrangement Own Rent \$_____/mo Subsidized Housing Exchange Services for Housing No Housing Payment Other:

Length at current address: less than 6 months 6-12 months 1-2 yrs More than 2 yrs # of moves in past 12 months: _____ Homeless in past 12 mths

Family currently has means of transportation: Yes No Type of Transportation: _____ Family has alternate means of transportation: Yes No

CONFIDENTIALITY POLICY In accordance with the Head Start/Early Head Start Performance Standards, all information obtained about children and families is confidential. Files are kept in locked file cabinets and Head Start/Early Head Start staff access is controlled on a "need to know" basis. A file control system is used to ensure confidentiality. Parents can make a written request to review their own child(ren)'s file(s) ONLY at any point during the program year. Professionals serving on federal and internal review teams are allowed to review files in their capacity as monitors of federal funding. Other agencies or organizations must obtain written parent/guardian consent to review information in a child/family file.

Certification: 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 have read and understand the Clinch Valley Community Action and Tazewell County Pre-K Program Confidentiality Policy.

Parent/Guardian's Signature: _____

Date: _____

For Head Start/Early Head Start Only:

Any specific family need or crisis? Yes No (If yes, please describe: _____)

Program: _____ Preferred Program Option: Center Based Home Based Center/Class Applying for: _____
School Year: _____ Year(s) in the Program: 1 2 3

Has the family income been verified? Yes No If so, what sources(s) were used to verify income?
 SSI documentation Income Tax Form 1040 W-2 Income Declaration Unemployment
 Child Support Written statements from employers Pay Stubs TANF documentation
 Foster care reimbursement Documentation of no income _____ Other _____

Has the child's age been verified? Yes No Birth Certificate #/State: _____ Hospital Record (Name of Hospital): _____

Immunization record attached? Yes No Proof of Residence verified by: _____ Physical attached? Yes No

I certify that the information contained in this application is accurate and truthful to the best of my knowledge. I certify that I have verified the information as specified.
Status: Complete _____ Accepted _____ Waiting List _____
Date Date Date

Staff Signature: _____ Date: _____
Staff Title: _____
Eligibility Determination Below Federal Poverty Guidelines 100-130% Federal Poverty Guidelines
 Over Income SSI/TANF Homeless Foster Care

ENROLLMENT
Teacher's Signature: _____ Enrollment Date _____
Teacher's Signature: _____ Withdrawal Date _____
Teacher's Signature: _____ Transfer Date _____

Child' Name: _____

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing Clinch Valley Community Action, Head Start/Early Head Start and Tazewell County Pre-K Program to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form for _____
(Full printed name of parent or guardian) (Full printed name of Head Start/Early Head Start child) (Child's Social Security Number)

My relationship to the child is: Parent Power of Attorney Guardian Other Legally Authorized Representative
(Address) (Child's Birth Date)

I want the following confidential information listed below but not limited to, to be exchanged:

- Financial information—Income verification
- Educational Records- Progress reports and PAL's testing
- Any medical records including:
 - recent physical,
 - up-to-date immunizations,
 - vision screening,
 - hearing screening,
 - any known allergies,
 - lead screening,
 - child's birth history and
 - hemoglobin.
- Any mental health records and or screenings
- Any speech screening and or evaluations
- Type of medical insurance, name or primary care provider
- Any dental records, name of dental provider
- Other- _____

I want Clinch Valley Community Action-Head Start/Early Head Start and Tazewell County Pre-K Program to be able to exchange this information with other agency. I want this information to be exchanged for the purpose of eligibility determination and services for the Head Start/Early Head Start and Tazewell County Pre-K programs. I want this information to be shared through written information

This consent is good through child;'

I can withdraw this consent at any time by telling the referring agency in writing. This will stop them from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared and why, when, and with whom it was shared. If I ask they will provide me this information to me. I want the school system to accept a copy of this form as a valid consent to share information. If I do not sign this form, information will not be shared and I will have to contact Clinch Valley Community Action—Head Start/Early Head Start or Tazewell County Pre-K Program to give them information about me that they need.

Signature of consenting person

Date

Signature of staff

Staff Title

Date