

Champlain Valley Head Start Application

1. Child Information / Age Eligibility

Child's Legal Name: _____
(First) (MI) (Last)

Child's Nickname: _____ Child's DOB: _____

Projected public school: _____ School cutoff date: _____

Head Start child's health insurance (circle primary): Medicaid/Dr. Dynasaur, Private, None, Other (please specify): _____

Insurance Carrier Group Number for child's health insurance: _____

Ethnicity of Head Start child (circle one): Hispanic/Latino Origin or non-Hispanic/non-Latino Origin

Race of Head Start child (circle one): Asian, Black/African American, American Indian/Alaska native, White, Biracial/Multi-racial, Native Hawaiian/Pacific Islander, Other (please specify): _____

Primary language spoken in home: _____ Is an interpreter needed? Yes No

2. Parent / Guardian Information

Primary Parent/Guardian
 Name: _____
 Living Address: _____
 City: _____ Zip Code: _____
 Mailing Address: _____
 City: _____ Zip Code: _____
 Home Phone #: _____ Cell Phone #: _____
 Work Phone #: _____ Other Phone #: _____
 Directions to home: _____

Parent/Guardian living outside the home
 Name: _____ Male/Female
 Mailing address: _____
 City: _____ Zip Code: _____
 Phone #: _____ DOB: _____
 Relationship to child: _____
 Are there any court orders? Y or N (circle one)
 Custody/Visitation: _____
 If there are custody orders, you must obtain a copy of the order.
 Copy of court order has been obtained: Yes or No

3. Household Members: List all persons living in the same household.

Name	Relationship	M / F	DOB	Social Security Number	Employment status	Job training / school status	Education level
Head Start child	HS child		Shown Above				
Parent / guardian	Parent / guardian						
(secondary adult, if applicable)							

Codes
Relationship A. Parent/Guardian B. Primary Parent/Guardian's significant other C. Grandparent D. Aunt/Uncle E. Sibling F. Other
Employment Status A. Employed B. Not working (unemployed, retired, disabled)
Job Training / School Status A. In job training or school B. Not in job training or school
Education Level A. Less than high school grad B. High school grad or GED C. Some college, vocational school, or associates degree D. Bachelor's or advanced degree

Does your family receive services through the WIC program? Y N

Does your family need full day and/or full year child care for your child (because parents are working or in job training)? Y N

If yes, is your child currently receiving care, or likely to receive care, in (circle one): family child care home, child care center/classroom, at home or at another home with a relative or unrelated adult, public school pre-K program, none, other (please specify): _____

Are you currently living in a shelter, sharing the housing of others, or living in a motel, car or campground? Y N

Does your family have a current housing crisis? Y N



CHAMPLAIN VALLEY HEAD START

431 Pine St. Burlington, VT 05401

802-651-4180
800-854-9648
fax: 802-658-0983

4. Child's Health Information (For those questions that do not apply, please write "None.")

Child's Legal Name: _____ DOB: _____
Child's Current Doctor: _____ Phone: _____ Date of last exam: _____
Child's Former Doctor: _____ Phone: _____ Date of last exam: _____
Child's Current Dentist: _____ Phone: _____ Date of last exam: _____
Child's Former Dentist: _____ Phone: _____ Date of last exam: _____
Chronic Health Condition(s): _____ Symptoms: _____
Current Medication(s): _____ Medication needed on site (circle): Yes No
Allergies (medications, food, bee stings, etc.): _____ Symptoms: _____

5. Releases and Authorizations

Head Start is a national preschool program, and Federal regulations require that Head Start preschool programs obtain documentation from health care providers regarding children's physical exams and dental exams. Head Start must also obtain documentation pertaining to children with special needs. The following release sets forth the information required of Head Start by Federal regulations in order to provide Head Start preschool services. Except as allowed in this authorization and release, CVHS will not communicate or disseminate any confidential child or family information to organizations or entities outside of CVHS.

A. Required Releases

I authorize the health care providers (medical and/or dental practices) listed above to release medical and/or dental records or information, including immunization records, regarding the above-named child to Champlain Valley Head Start. I authorize Champlain Valley Head Start to obtain my child's immunization records from the Vermont Immunization Registry.

I authorize the local school district which currently maintains my child's comprehensive evaluation and/or IFSP or IEP to release these documents to Champlain Valley Head Start.

I authorize any state or Federal agencies administering public assistance benefits including but not limited to RUFA/Reach Up, SSI, Childcare Subsidy, or foster care to provide Champlain Valley Head Start with documentation verifying my family's receipt of public assistance.

I authorize CVHS to acquire or release information regarding my child or family with organizations or entities that, in the opinion of CVHS, may be able to provide or support services to my child or family directly or in conjunction with CVHS.

In the event of an emergency, I authorize the staff or collaborative partners of Champlain Valley Head Start to seek any necessary treatment or emergency medical care for my child.

I consent to have my child participate in all health and developmental screenings or exams conducted by Champlain Valley Head Start or its collaborative partners in order for Champlain Valley Head Start to comply with Federal Head Start regulations.

B. Photographs: I give my permission to Champlain Valley Head Start to use photographs of my child in Head Start recruitment materials or newsletters. Circle one: Yes No

C. Child Pick-Up and Release / Permission to Transport Plan

I give my permission for my child to be released to the following people for the purposes of pick-up and/or transportation to/from CVHS activity sites. (Include the child's other parent and other family members who may be likely to transport the child.) The parent/guardian understands that his/her child will only be released to persons identified on the following list. Anyone who is unknown to CVHS staff must show identification. I give my permission for my child to be transported to and from CVHS activities by any transportation service with whom CVHS may contract for transportation of children in the CVHS program, and to release the name and address of my child to transportation services contracted by CVHS for the purpose of CVHS activities.

Emergency Contact People: Emergency Contact People must be able to transport the child in the event of an emergency if the CVHS parent or legal guardian cannot be reached. Emergency contacts must be aware they are designated as such. Emergency contacts unknown to CVHS staff must produce identification before a child is released. (Please indicate which of the people listed below is an emergency contact in the far right column.)

Table with 5 columns: Name, Relationship to Child, Home Phone, Work/Cell Phone, Emergency Contact (Y/N). It contains five empty rows for data entry.

Parent/guardian signature: _____ Date: _____
Parent/guardian's phone number(s): _____

6. Family Income / Eligibility Verification Family income must be verified by the Head Start program before determining that a child is eligible to participate in the program. Verification must include examination of any of the following: individual income tax form 1040, W-2 forms, pay stubs, pay envelopes, written statements from employers, or documentation showing status as recipients of public assistance. By circling the document(s) indicated below, the CVHS staff person is indicating that he/she has seen the document(s) circled.

A. Is the child currently in Foster Care? *If yes, circle documentation seen and skip section D; if no, go to section B.*

Foster Care Documentation seen by staff (circle one): Foster Care Custody Order/Agreement DCF Documentation

B. Is the family homeless? Yes No *If yes, please have family review and sign Self-Declaration of Homelessness; if no, go to section C.*

C. Does the family currently receive any of the following Public Assistance Benefits? *If yes, circle documentation seen for any and all types of public assistance benefits the family currently receives and skip section D; if no, go to section D.*

Public Assistance Documentation seen by staff (circle all seen): RUFA Reach Up SSI Child Care Subsidy (employment/education/training)

D. Family income (complete this section only if section A and section B and Section C do not apply)

	Type of income	Documentation seen by staff	Income calculation			Total
			Frequency of income period (Weekly, bi-weekly, monthly, semi-monthly, annual; if "other" please specify)	Amount	# of income periods (in past 12 months or last complete calendar yr)	
Parent/guardian 1						
Parent/guardian 2						
Total gross annual income (past 12 months or last complete calendar yr)						

Number of people supported by family income: _____

Type of income - codes	Income documentation seen - codes
A. Work wages	A. Income tax form
B. Unemployment compensation	B. W-2 form
C. Workers compensation	C. Pay stubs
D. Social Security benefits (not to be confused with SSI)	D. Pay envelopes
E. Veterans benefits	E. Written statement from employer
F. Child support	
<u>If "Other income", specify what type of income</u>	<u>If "Other documentation", specify what document</u>

E. Child and Family Income / Eligibility Summary (check one)

_____ The child is eligible to participate in the Head Start program (income-eligible based on foster care, homelessness, public assistance or Head Start income guidelines)

_____ The child is from an over-income family

7. Special Needs

Circle any of the following which apply to your child: Speech & Language Impairment, Emotional/Behavioral Disability,
Impairment of Motor Function, Learning Impairment, Hearing Impairment/Deafness, Developmentally Delayed,
Visual Impairment/Blindness, Other Health Impairment (specify): _____

My child is on/has had (please circle, if applicable): IFSP IEP Comprehensive Evaluation

if applicable : Date completed: _____ Where completed: _____

Please specify any concerns you may have about your child's behavior or development: _____

8. Outreach

Where did you hear about Champlain Valley Head Start? (please check one):

- Poster/Brochure
- Friend/Family Member
- CVHS Teacher/Home Visitor
- Newspaper/Magazine Ad (please specify): _____
- CVHS Booth at an event (please specify): _____
- Service Provider [such as VNA, WIC] (please specify): _____
- Other (please specify): _____

9. Staff and Parent Signatures

This application signifies the family's desire to enroll the child in the Head Start program. Following completion of this application, the application will be processed and Champlain Valley Head Start will notify the family as to whether the child has been enrolled in the program, and the starting date for preschool and family services.

By signing below, the **parent/guardian** indicates that he/she intends to enroll his/her child in Head Start if the child is accepted into the program. Furthermore, he/she agrees to comply with the rules and regulations of the program. The parent/guardian further certifies via his/her signature on this form that the information he/she has provided is accurate and truthful to the best of his/her knowledge.

Parent / Guardian Signature _____ **Date:** _____

The **Head Start staff** signature below confirms that the staff person determined the child and family's eligibility to participate in the Head Start program based upon examining the documents listed above, and certifies that the information provided in this application is accurate and truthful to the best of his/her knowledge.

Head Start Staff Member Signature _____ **Date:** _____

Head Start Supervisor Signature _____ **Date:** _____