Tazewell County Preschool Partnership **Pre-K / Head Start / Early Head Start** **Application** **2019-2020**	**Physical Address** _____ _____ _____	**Mailing Address** _____ _____ _____ **E-Mail** _____	**Primary Phone: _H_C** _____ **Alternate Phone _H_C** _____

Child Information

Last	First	Middle	Date of Birth	Social Security #	Gender	Related to Primary Adult	How Related	Disabilities	Primary Lang.	Race	Dual Custody
					M ___ F ___	Yes ___ No ___					Yes ___ No ___

Previous Child Care/School:	**Current Child Care/School:**

Father/Male Guardian

Last	First	Middle	Date of Birth	Education Level	Employment Status	Race	Lives In Household With Child	Financial Support	Teen Parent	School Drop-Out
							Yes ___ No ___	Yes ___ No ___	Yes __ No __	Yes ___ No ___

Employer:	Contact Person:	Phone:

Mother/Female Guardian

Last	First	Middle	Date of Birth	Education Level	Employment Status	Race	Lives In Household With Child	Financial Support	Teen Parent	School Drop-Out
							Yes ___ No ___	Yes ___ No ___	Yes __ No __	Yes ___ No ___

Employer:	Contact Person:	Phone:

Other Siblings, Children, Relatives Living in Home (include all siblings and any other family members)

Last	First	Middle	Date of Birth	Gender	Related to Child	How Related	Race	Education Level	Current School
				M ___ F ___	Yes ___ No ___				
Last	First	Middle	Date of Birth	Gender	Related to Child	How Related	Race	Education Level	Current School
				M ___ F ___	Yes ___ No ___				
Last	First	Middle	Date of Birth	Gender	Related to Child	How Related	Race	Education Level	Current School
				M ___ F ___	Yes ___ No ___				

Additional Household Information

Alternate Phone :	Home ___	Cell ___	Work ___	Message ___
Alternate Phone :	Home ___	Cell ___	Work ___	Message ___

Number in Family: _____	Number of Children: _____	Number of Children by Age _____ 0-4 _____ 4-5 _____5 +

Family Type _____ Two Parent Family _____ Female Single Parent _____ Male Single Parent _____Foster Family _____Grandparent
_____ Female Single Parent Living w/Partner _____ Male Single Parent Living w/Partner _____ Other Relative _____ Other, Specify _____

Directions to Home (***Must be completed to ensure placement at correct school location***) :

_____

_____

_____

_____

Release Child to	**Relationship**	**Contact Number**	**CUSTODY PAPERS SIGNED BY A COURT AUTHORITY MUST BE PROVIDED IF A BIOLOGICAL PARENT IS NOT ALLOWED TO PICK UP CHILD.**
Name:			
Name:			
Name:			
Name:			

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

Type of Services and/or Financial Assistance Received By Family

___ No Services	___ Child Support / Alimony	___Medical Assistance	___ Public Assistance / DSS	___ Energy Assistance
___ EPSDT	___ Public Housing Assistance	___ Food Stamps	___ Foster Care	___ Adoption Subsidy
___ Unemployment	___ SSI, Whom:	___ WIC	___ Other	

Type of Housing

___ House	___ Apartment	___ Mobile Home	___Community Shelter	___ Homeless/ No Housing	___ Relative/ Friend	___ Other: _____

Housing Payment Arrangement

___ Own	___ Rent $_____ month	___ Subsidized Housing	___ Exchange Services for Housing	___ No Housing Payment	___ Other: _____	

Length at Current Address						
___ Less than 6 months	___ 6-12 months	___ 1-2 years	___ More than 2 years		Number of moves in past 12 months: _____	Homeless in the past 12 months: ___ Yes ___ No
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 and the Policies and Procedures of the Tazewell County Public Schools, all information obtained about children and families is confidential. Files are kept in locked file cabinets and 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/or 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 Signature: _____ Date: _____

All Applications Should Be Returned to the Following Address:

Tazewell County Pre-School Partnership
200 East Riverside Drive
PO Box 188
North Tazewell, VA 24630

Applications returned to Tazewell County elementary schools will be forwarded to the above address.

A selection committee will determine if your child is eligible for participation in either the Early Head Start, Head Start, or Pre-K program. This selection committee will place each child in the appropriate program. No child can be considered for eligibility, nor any application processed, without ALL necessary documentation.

Please indicate any suspected and/or diagnosed disabilities or health conditions that affect your child. This information does not impact your child's eligibility to participate in programs, but it is necessary to ensure that the best placement is made for your child and that appropriate accommodations are in place.

_____ Parent/Guardian Reports and Records Indicate No Disabilities and/or Health Concerns

Disabilities	Suspected	Identified	Date	Evaluated By	Health Concerns	Suspected	Identified	Date	Evaluated By
Autism					Diabetes				
Health Impairment					Food Allergies				
Learning Disability					Other Allergies (not including seasonal allergies)				
Multiple Disabilities					Asthma				
Orthopedic Impairment					Seizures				
Traumatic Brain Injury					Gastro-Intestinal Disorders (such as lactose intolerance, Celiac Disease)				
Emotional/Behavioral					Please list any health condition not included above that may require accommodations:				
Hearing Impairment									
Mental Retardation									
Non-Categorical/ Developmental Delay									
Speech/Language Impairment					Does your child require any medication that would need to be administered while at school such as an EpiPen or seizure medication that must be available at all times?				
Visual Impairment									
ADD/ADHD/ODD (please circle)					___ Yes ___ No If Yes, please list _____				

*Reminder: A child must be potty-trained before he/she can participate in the Pre-K program. Children do not have to be potty-trained in order to participate in either the Head Start or Early Head Start programs.

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)

_____ _____

(Address) (Child's Birth Date)

My relationship to the child is: ❒ Parent ❒ Power of Attorney ❒ Guardian ❒ Other Legally Authorized Representative

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 agencies. 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. This consent is good through child's seventh birthday.

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 Parent/Guardian **Date**

_____ _____ _____

Signature of Staff Person **Title** **Date**

Do Not Complete/For Pre-School Partnership Only

Any specific family need or crisis? ❒ Yes ❒ No (If yes, please describe:			
Program:	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 ❒ Homeless /McKinney Vento	❒ 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 I have verbally interviewed (either in person or via telephone) parent/ guardian to verify the completeness and accuracy of the information contained on this application.	Status: ❒ Complete _____ ❒ Accepted _____ ❒ Waiting List _____		
	Date	Date	Date

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

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.		
Staff Signature:	Staff Title: Partnerships/ERSEA coordinator	Date: