

# Tazewell County Pre-School Partnership

PEOPLE HELPING PEOPLE

200 E. Riverside Drive • P O Box 188 • North Tazewell, VA 24630  
276-988-5583 • 276-988-4041 Fax  
[www.clinchvalleycaa.org](http://www.clinchvalleycaa.org)

Dear Families:

Attached you will find an application for Pre-K, Head Start, and Early Head Start. This application serves all three programs. A selection committee will make the determination as to your child's placement and you will be notified by the **first week of August** of the placement. No placement decisions will be discussed with you prior to this time, nor will any child be discussed with anyone other than the child's parent or legal guardian.

Please remember that your child's application **CANNOT** be processed without **ALL** the necessary documents.

**These documents include:**

- Proof of Income or Completion of Homeless or No Income Form**  
**Check stubs need to be for the most recent 4 week period prior to completing the application. Additionally, a W2 or Income Tax Forms may be used. If you receive TANF or SSI please provide documentation.**
- Proof of Birth – for Pre K must provide a copy of birth certificate with application and upon enrollment to the Pre K program the original birth certificate must be presented to the school staff that is enrolling your child. Head Start and Early Head Start can use a birth certificate or a birth letter for enrollment.**
- Two Documentations of Physical Address**

Additionally, if you attach a completed physical and/or current immunization record your child's application will receive selection points for these items.

Sincerely,

Tazewell County Pre-School Partnership



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 ( <i>Must be completed to ensure placement at correct school location</i> ) :						
_____						
_____						
_____						
_____						
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						
<input type="checkbox"/> Less than 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> 1-2 years	<input type="checkbox"/> More than 2 years		Number of moves in past 12 months: _____	Homeless in the past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Family currently has means of transportation <input type="checkbox"/> Yes <input type="checkbox"/> No			Type of Transportation	Family has alternate means of transportation <input type="checkbox"/> Yes <input type="checkbox"/> 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									
Visual Impairment									
ADD/ADHD/ODD (please circle)									

\*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)

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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe:					
Program:	Program Option: <input type="checkbox"/> Center Based	<input type="checkbox"/> Home Based	Center/Class Applying for:		
School Year:	Year(s) in the Program: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3				
Has the family income been verified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what sources(s) were used to verify income?			
		<input type="checkbox"/> SSI documentation	<input type="checkbox"/> Income Tax Form 1040	<input type="checkbox"/> W-2	<input type="checkbox"/> Income Declaration
		<input type="checkbox"/> Child Support	<input type="checkbox"/> Written statements from employers	<input type="checkbox"/> Pay Stubs	<input type="checkbox"/> Unemployment
		<input type="checkbox"/> Foster care reimbursement	<input type="checkbox"/> Documentation of no income		<input type="checkbox"/> Other _____
Has the child's age been verified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Certificate #/State:		Hospital Record (Name of Hospital):	
Immunization record attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Proof of Residence verified by: _____		Physical attached? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Complete _____		<input type="checkbox"/> Accepted _____	<input type="checkbox"/> Waiting List _____
		Date		Date	Date
Staff Signature:	Date:	Eligibility Determination	<input type="checkbox"/> Below Federal Poverty Guidelines		<input type="checkbox"/> 100-130% Federal Poverty Guidelines
Staff Title:			<input type="checkbox"/> Over Income	<input type="checkbox"/> SSI/TANF	<input type="checkbox"/> Homeless
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:

Self-Declaration of No Income

I, \_\_\_\_\_, have had no income over the past 12 months.

I, \_\_\_\_\_, have had no income for the time period of \_\_\_\_\_ to \_\_\_\_\_.

My basic needs such as housing, utilities, etc. are met in the following ways:

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\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



## CVCA – HEAD START/EARLY HEAD START

### Self Identification for Homeless and Highly Mobile Children

Families who are currently homeless are income eligible for Head Start/Early Head Start services. Please answer the questions below that best describes your living situation. The purpose of this information is to ensure the rights of your children and youth under the McKinney-Vento Homeless Assistance Act of 2001.

Do you or your family live in any of these situations? (Check all that apply.)

- In a shelter (family shelter, domestic violence, youth, or temporary housing)
- In a motel, hotel, or weekly rate housing
- Doubled up with friends or relatives because you cannot find or afford housing
- In an abandoned building, other inadequate accommodation, or in a car
- On the street
- In temporary foster care
- With friends or family because you are an unaccompanied youth

Yes, I/we are currently living in one of these situations.

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Parent/Guardian Signature

Date

The McKinney-Vento Homeless Assistance Act assures education rights for homeless and highly mobile students. This information is confidential.