

Tazewell County Pre-School Partnership

PEOPLE HELPING PEOPLE

1379 Tazewell Avenue • P O Box 188 • North Tazewell, VA 24630
276-988-5583 • 276-988-4041 Fax
www.clinchvalleycaa.org

Dear Families:

Attached you will find an application for PreK (child must be 4 by September 30), Head Start (child must be 3 or 4 by September 30), and Early Head Start (child may be birth to age 3; pregnant women are also eligible). This application serves all three programs. A selection committee will make the determination as to your child's placement. The selection committee will begin making placements during the **first week of July from eligible applications** and will continue to place children until all available slots are filled. **Parents/guardians will receive notification of their child's placement during the first two weeks of August.** No placement decisions will be discussed 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, completion of Homeless Form (with documentation of any household income), or No Income Form**
Check stubs need to be for the most recent 4 week period prior to completing the application or a W2 or Income Tax Forms may be used. If you receive TANF or SSI please provide documentation.
- **Foster Care Documents (if applicable) – proof of income must be included in addition to these documents in order to determine eligibility for Pre K.**
- **Proof of Birth – Pre K applicants must provide a copy of child's birth certificate with application; upon enrollment to the Pre K program the original birth certificate must be presented to the school staff member who is enrolling child. Head Start and Early Head Start may use a birth certificate or a birth letter for enrollment. If you do not have these items and need help obtaining them, please contact the Tazewell County Pre-School Partnership for assistance.**
- **Two Items Documenting Physical Address**
- **If you indicate that you child has a current, diagnosed disability, please provide a copy of his/her IEP or IFSP with application.**

Sincerely,

Tazewell County Pre-School Partnership

Tazewell County Preschool Partnership Pre-K / Head Start / Early Head Start Application 2020-2021	Physical Address _____ _____ _____	Mailing Address _____ _____ _____ E-Mail _____	Primary Phone: _H_C _____ Alternate Phone _H_C _____
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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:
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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 (<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:					
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 _____
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: _____
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	
Homeless in the past 12 months: <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:** _____

<p>All Applications Should Be Returned to the Following Address:</p> <p>Tazewell County Pre-School Partnership 200 East Riverside Drive PO Box 188 North Tazewell, VA 24630</p> <p>Applications returned to Tazewell County elementary schools will be forwarded to the above address.</p>	<p>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.</p>
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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					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?				
ADD/ADHD/ODD (please circle)						<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ (Child's Social Security Number)

(Full printed name of parent or guardian) (Full printed name of Head Start/Early Head Start child)

_____, _____ (Child's Birth Date)

(Address) (Other Legally Authorized Representative)

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 _____
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"/> Homeless /McKinney Vento
		<input type="checkbox"/> Child Support	<input type="checkbox"/> Written statements from employers		<input type="checkbox"/> Pay Stubs
		<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 <input type="checkbox"/> 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:

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:

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.

Parent/Guardian Signature

Date

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

***Homeless status automatically qualifies a child for Head Start/Early Head Start services. In order to be considered for the Pre-K program, documentation of family income must still be provided in addition to the completion of this form.**