Clinch Valley Community Action Head Start

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 the Head Start programs in Bland, Smyth, and Wythe Counties operated by Clinch Valley Community Action. In order to enroll in the Head Start program at the beginning of the program year in August, your child must turn 3 by September 30, 2021. A child who turns 3 after this date is eligible to enroll in the program at any time after his/her third birthday. Head Start is available for children three-years-old through the time they are eligible for kindergarten. 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** 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 – 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 Clinch Valley Community Action Head Start program in your area 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,

Clinch Valley Community Action Head Start

Clinch Valley Community Action **Bland, Smyth, Wythe Head Start** **Application** **2021-2022**	**Physical Address** _____ _____ _____	**Mailing Address** _____ _____ _____ **E-Mail** _____	**Primary Phone: _H_C** _____ **Alternate Phone _H_C** _____ **Work Phone:** _____

Child Information

Last	First	Middle	Date of Birth	Social Security #	Gender	Related to Primary Adult	How Related	Disabilities	Primary Lang.	Dual Custody
					M __ F __	Y ___ N___				Y __ N __

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

Guardian 1

Last	First	Middle	Date of Birth	Education Level	Employment Status	Lives In Household With Child	Financial Support	School Drop-Out /GED
						Y ___ N ___	Y ___ N ___	Y ___ N ___

Employer:	Contact Person:	Phone:

Guardian 2

Last	First	Middle	Date of Birth	Education Level	Employment Status	Lives In Household With Child	Financial Support	School Drop-Out / GED
						Y ___ N ___	Y ___ N ___	Y ___ N ___

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
				M ___ F ___	Y ___N ___	
Last	First	Middle	Date of Birth	Gender	Related to Child	How Related
				M ___ F ___	Y ___N ___	
Last	First	Middle	Date of Birth	Gender	Related to Child	How Related
				M ___ F ___	Y ___N ___	

Additional Household Information

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
_____ Other Relative _____ Other, Specify _____

Emergency Contact Information (List Individuals OTHER THAN Guardian1 and Guardian 2)			
Emergency Contact 1 (name, relationship)	Physical Address:		Phone:
	City:	State:	Zip:
Emergency Contact 2 (name, relationship)	Physical Address:		Phone:
	City:	State:	Zip:

CUSTODY PAPERS SIGNED BY A COURT AUTHORITY MUST BE PROVIDED IF A BIOLOGICAL PARENT IS NOT ALLOWED CONTACT WITH CHILD.

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	

Transportation			
Family currently has means of transportation ___ Y ___ N	**Type of Transportation**	**Family has alternate means of transportation** ___ Y ___N	Will child normally ride bus if available ___ Y ___ N

CONFIDENTIALITY POLICY: In accordance with the Head Start/Early Head Start Performance Standards and the Policies and Procedures of Clinch Valley Community Action, 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 Confidentiality Policy.

Parent/Guardian Signature: _____ Date: _____

Applications may be returned to the following address or can be completed online:

Clinch Valley Community Action
Bland, Smyth, Wythe Head Start
1379 Tazewell Avenue
PO Box 188
North Tazewell, VA 24630

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

Please indicate any suspected disabilities, health conditions, or at-risk criteria that affect your child. This information helps to ensure that the best placement is made for your child and that appropriate accommodations are in place.

_____ Guardian Reports and Records Indicate No Disabilities, Health Concerns, or At-Risk Criteria

Disabilities	Yes/No	At Risk Criteria	Yes/No
Autism	___Y ___N	Child demonstrates a special need/disability that will be best addressed in an inclusive classroom	___Y ___N
Health Impairment	___Y ___N		
Learning Disability	___Y ___N	Child is being raised by someone other than parent	___Y ___N
Multiple Disabilities	___Y ___N	Child is being raised by a single parent	___Y ___N
Orthopedic Impairment	___Y ___N	History of drug abuse/use in the household	___Y ___N
Traumatic Brain Injury	___Y ___N	Child is in foster care or at risk based on involvement in the child welfare system	___Y ___N
Emotional/Behavioral	___Y ___N		
Hearing Impairment	___Y ___N	Family meets McKinney-Vento homeless criteria	___Y ___N
Mental Retardation	___Y ___N	Child born premature or with health issues at birth which have impacted development	___Y ___N
Non-Categorical/ Developmental Delay	___Y ___N		
Speech/Language Impairment	___Y ___N	Child born addicted to drugs	___Y ___N
Visual Impairment	___Y ___N	Child has current identified health issues	___Y ___N
ADD/ADHD/ODD (please circle)	___Y ___N	Child is receiving counseling services	___Y ___N
Health Concerns	___Y ___N	Child is a dual language learner	___Y ___N
Diabetes	___Y ___N	A family member suffers from abuse including all forms of trauma and/or adverse childhood experiences as reported by family	___Y ___N
Food Allergies	___Y ___N		
Other Allergies (not including seasonal allergies)	___Y ___N		
Asthma	___Y ___N	A parent/caregiver is incarcerated	___Y ___N
Seizures	___Y ___N	A parent is on military deployment	___Y ___N
Gastro-Intestinal Disorders (such as lactose intolerance, Celiac Disease, etc.)	___Y ___N	Negative impact of COVID-19 on family/child	___Y ___N

Please list any health condition not included above that may require accommodations:	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? ___Y ___N If Yes, please list: _____

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:

_____
_____
_____
_____
_____

Self Identification for Homeless and Highly Mobile Children

Families who are currently homeless are categorically eligible for Head Start/Early Head Start services. Please answer the questions below that best describe 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.

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

Do you or your family live in any of these situation? (check all that apply)

___ In a shelter (family, 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.

By signing below, I certify that I/we are currently living in one of these situation.

Parent/Guardian Signature: _____

Date: _____

Staff Signature: _____

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 to exchange certain information with various entities 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 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 program. 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**
	❒ Social Security				
	❒ 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:**