

Shenandoah Valley Early Childhood Education Application 2019-2020

Counties of Augusta, Bath, Highland, Rockingham, and the cities of Harrisonburg, Staunton, and Waynesboro

Placements provided through Early Childhood Special Education, Early Head Start, Head Start, Local, and Virginia Preschool Initiative funding.

Family Information

Child's Name: _____ **Date of Birth:** _____
First Middle Last

Address: _____
Street/Route City State Zip

If mailing address is different than living address please list here: _____

Please check form of residency verification included with application: utility bill check stub with home address tax document

Gender: Male Female **First/Primary Language of Child:** English Spanish Other: _____

Race: Asian Black Pacific Islander White American Indian/Alaska Native Other: _____

Ethnicity: Hispanic Yes No

Primary Adult's preferred language for school communication: English Spanish Other: _____

Elementary School District: _____

Parent/Guardian: _____ **Primary #:** _____ **Alt #:** _____

Parent/Guardian: _____ **Primary #:** _____ **Alt #:** _____

Emergency Contact: _____ **Primary #:** _____ **Alt #:** _____

Email: _____ **Permission to Text:** Yes No

Household Profile:

| List <u>ALL</u> members of the household: | Date of Birth | Relationship to child: | Employment status: | Education |
|--|---------------|---|--|--|
| Primary Adult: _____ Has legal custody of applicant: <input type="checkbox"/> yes <input type="checkbox"/> no If no, please state how child is in your care: _____ | | <input type="checkbox"/> birth parent <input type="checkbox"/> step parent, married <input type="checkbox"/> parent's partner, unmarried <input type="checkbox"/> foster or adoptive parent <input type="checkbox"/> legal guardian <input type="checkbox"/> unofficial guardian | <input type="checkbox"/> full time (>35 hrs. a week) <input type="checkbox"/> part time (<35 hrs. a week) <input type="checkbox"/> retired or disabled <input type="checkbox"/> training or school <input type="checkbox"/> unemployed <input type="checkbox"/> seasonally employed | <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Adv. Training Certificate <input type="checkbox"/> Some College or Training <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Did Not Graduate <input type="checkbox"/> Other: _____ |
| Secondary Adult: _____ Has legal custody of applicant: <input type="checkbox"/> yes <input type="checkbox"/> no If no, please state how child is in your care: _____ | | <input type="checkbox"/> birth parent <input type="checkbox"/> step parent, married <input type="checkbox"/> parent's partner, unmarried <input type="checkbox"/> foster or adoptive parent <input type="checkbox"/> legal guardian <input type="checkbox"/> unofficial guardian | <input type="checkbox"/> full time (>35 hrs. a week) <input type="checkbox"/> part time (<35 hrs. a week) <input type="checkbox"/> retired or disabled <input type="checkbox"/> training or school <input type="checkbox"/> unemployed <input type="checkbox"/> seasonally employed | <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Adv. Training Certificate <input type="checkbox"/> Some College or Training <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Did Not Graduate <input type="checkbox"/> Other: _____ |

Siblings or Others in the Household Date of Birth

| | |
|----------------------------|--|
| Name: | |
| Relationship to Applicant: | |
| Name: | |
| Relationship to Applicant: | |
| Name: | |
| Relationship to Applicant: | |
| Name: | |
| Relationship to Applicant: | |

Health Coverage

Primary Health Coverage: FAMIS Medicaid Private
 Other Do Not Have Insurance

Insurance/Medicaid Provider: _____

Insurance/Medicaid Number: _____

Doctor's Name: _____

Dentist's Name: _____

Income Documentation

Income is requested for consideration of services. Include ALL income sources for the family. (All information is confidential.)

| Name of parent/legal guardian receiving income | Place of employment or income source | How often is income received? | Gross amount? (before taxes) |
|--|--------------------------------------|--|------------------------------|
| | | <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice a month <input type="checkbox"/> every 2 weeks <input type="checkbox"/> quarterly <input type="checkbox"/> yearly | |
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Check all documentation family is providing and ATTACH to this application:

- 1040 Tax Form W-2 Current Pay Stub Child Support Documentation Employer Letter
 Disability/Social Security Letter TANF Award Letter SSI Award Letter "0" Income Letter
 Other _____

Office Use Only _____ Verification Signature/Date _____

Child and/or Family Factors

This is a needs based program. Please check as many family factors that apply. Placements on the waitlist and a large part of preschool acceptances are determined by the number of family factors checked.

- Single parent family
- Child's parents are divorced/separated
- Child has no contact with one or both parents
- Child does not live with his/her parents
- Child or siblings have been removed from the home
- Child is/was in foster care
- Diversionary agreement, safety plan, or kinship care in place for child
- Parent of child is deceased
- Parent(s) or other member of household incarcerated
- Parent absent from the home: works out of town, long term hospitalization, or military service
- Both /all parents/legal guardians unemployed
- Family has moved more than 2 times within the last year
- Housing concerns: overcrowded, needs major repairs, lack of heat, etc.
- Family is living in temporary housing
- Family has nutritional needs
- No driver's license holder in household
- Family is receiving WIC
- Family is receiving SNAP
- No other preschool services available for this child.
State why: _____
- Parent(s) did not finish high school (U.S. or native country)
- Parent(s) has limited reading skills in primary language
- Parent(s) has limited English proficiency
- Child is an English Language Learner
- History of parental substance abuse
- Domestic violence in the home
- Protective order is in place for this child
- Child has been abused (physically, sexually or emotionally)
- Child or family is in counseling
- Household member has diagnosed depression or other mental illness
- Teen mother or father at child's birth (under 20 yrs. of age)
- Child was born before 37 weeks
- Child weighed less than 5 lbs at birth
- Child has a disability
- Sibling has a disability
- Parent has a disability
- Child does not have medical insurance
- Child does not have a regular pediatrician and/or dentist
- Parent has a long term or chronic illness
- Child has a medical condition. Please list condition: _____

Is your child currently enrolled in a daycare/preschool service? Yes No If yes, where: _____

Does your family receive a Child Care Subsidy/Assistance? Yes No

Do you have concerns about your child in the following areas?

- Weight Sleep Patterns Eating Habits Health Development Behavior Social Interactions Speech

If yes, what is the concern? _____

Has this child ever been referred to or evaluated by the school system or other facility for special education, speech, infant education, or preschool services? Yes No When? _____ Where? _____ Outcome: _____

Does he/she have an IFSP, IEP, or is he/she currently receiving services? Yes No

I give permission for (Shenandoah Valley Early Childhood Education Programs, Department of Social Services, Infant Toddler Connection, and/or other Early Intervention Program _____) to exchange personal information regarding services my child and family receive until my child leaves the program.

Signature: _____

Case worker's name/Organization: _____

I DO NOT give consent for any information to be shared between any of the above that have been crossed out.

Acknowledgement

I certify that, to the best of my knowledge, the information provided in this application is true and accurate. I understand that if any of this information changes or is found to be incorrect, I am obligated to notify this agency immediately. I understand that falsifying information such as family income, number of children, number of household members or relationship may result in the rejection of this application.

Federal Law prohibits discrimination on the basis of race, color, national origin, sex, disability or age.

Parent/Guardian's Name (print) _____

Parent/Guardian's Signature _____ Date _____

Return Application and Required Documentation To:

Shenandoah Valley Head Start/Early Head Start
Attn: ERSEA Manager
939A Fir Street
Waynesboro, VA 22980
Phone: 540-942-7111 ext. 110 Fax: 540-943-6208

SVHS/EHS Office Use Only:

| | | |
|------------------------------|-------------------------------|---------------------------------|
| <input type="checkbox"/> AC | <input type="checkbox"/> DE | <input type="checkbox"/> HB |
| <input type="checkbox"/> HES | <input type="checkbox"/> EE | <input type="checkbox"/> EHS-WH |
| <input type="checkbox"/> MES | <input type="checkbox"/> RCPS | <input type="checkbox"/> EHS-WL |
| <input type="checkbox"/> VES | <input type="checkbox"/> WH | |

Staff signature _____ Date _____

Face-to-face _____ Phone: reason _____

Approved 12/6/18