Shenandoah Valley Early Childhood Education Application 2016-2017

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.

General

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**

Elementary School District :_____

Contact Numbers:	**Contact Name:**	
Primary Telephone #:		☐ cell ☐ work ☐ home
Alternate Telephone #:		☐ cell ☐ work ☐ home
Emergency Contact #:		☐ cell ☐ work ☐ home

Household Profile:

List ALL family members living in the home in the boxes below:	**Date of Birth (mm/dd/yyyy)**	**Indicate adult's relationship to child:**	**Check current adult employment status:**	**Highest Grade Completed**
Primary Adult: _____ Has legal custody of applicant: ☐ **yes** ☐ **no** If no, please state how child is in your care:		☐ birth parent ☐ step parent, married ☐ parent's partner, unmarried ☐ foster or adoptive parent ☐ legal guardian ☐ unofficial guardian	☐ full time (35 hrs. or more a week) ☐ part time (under 35 hrs. a week) ☐ retired or disabled ☐ training or school ☐ unemployed ☐ seasonally employed	
Secondary Adult: _____ Has legal custody of applicant: ☐ **yes** ☐ **no** If no, please state how child is in your care:		☐ birth parent ☐ step parent, married ☐ parent's partner, unmarried ☐ foster or adoptive parent ☐ legal guardian ☐ unofficial guardian	☐ full time (35 hrs. or more a week) ☐ part time (under 35 hrs. a week) ☐ retired or disabled ☐ training or school ☐ unemployed ☐ seasonally employed	

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:**	

Demographics of Child Applying

Sex of Child: ☐ Male ☐ Female
First/Primary Language of Child: ☐ English ☐ Spanish ☐ Other: _____
Primary Adult's preferred language for school communication:
☐ English ☐ Spanish ☐ Other: _____

Race of Child:
___Asian ____Black ____Pacific Islander ____White
____American Indian/Alaska Native ____Other

Ethnicity of Child:
Hispanic ___Yes ___No

HEALTH COVERAGE

Primary Health Coverage:
___FAMIS ___Medicaid ___Private Health Insurance ___ Other

Insurance Number: _____ **Medicaid Number:** _____ ☐ **DO NOT HAVE INSURANCE**
Doctor's Name: _____ **Dentist's Name:** _____

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

Name of parent/legal guardian receiving income	**Place of employment/ income source**	**How often is income received?**	**Gross amount? (before taxes)**
		☐**hourly** ☐**weekly** ☐**monthly** ☐**twice a month** ☐**yearly** ☐**every 2 weeks** ☐**quarterly**	
		☐**hourly** ☐**weekly** ☐**monthly** ☐**twice a month** ☐**yearly** ☐**every 2 weeks** ☐**quarterly**	

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 ___Other
___Declaration of "0" Income Letter ___Other Documentation of Income

Office Use Only _____ Verification Signature

Child and/or Family Factors: ***This is a needs based program so 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.***

_____ Child's parents did not marry
_____ 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
_____ Deceased parent (of child)
_____ Incarcerated parent(s)
_____ 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.
_____ Homeless family (lack a fixed, permanent residency)
_____ Family has nutritional needs
_____ No drivers license holder in household
_____ Family is receiving WIC
_____ 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 has limited English proficiency
_____ Parental substance abuse history
_____ Domestic violence in the home
_____ Child has been abused (physically, sexually or emotionally)
_____ Child or family is in counseling
_____ Teen mother or father at child's birth (under 20 yrs. of age)
_____ Premature birth (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
_____ Parent has a long term or chronic illness
_____ Child does not have a regular pediatrician and/or dentist
_____ Child has a medical condition. Please list condition: _____

Do you have concerns about your child in the following areas? Please circle all that apply.
Underweight Overweight Sleep Patterns Eating Habits Social Interactions

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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? _____When? _____ Where? _____ Outcome: _____
Does he/she have an IEP or are they currently receiving services for the diagnosis above? _____

Are you concerned about this child's **health**, **development**, **speech**, or **behavior** at this time? ☐ Yes ☐ No
If yes, what is the concern?:_____
_____

Is your child currently enrolled in a daycare/preschool service? ☐Yes ☐No If yes, please state the name of the daycare/preschool:_____

Does your family receive: (Circle) **SNAP WIC Medicaid Child Care Subsidy/Assistance**
Case worker's name: _____

__ I give permission for Shenandoah Valley Early Childhood Education Programs and my local Department of Social Services to exchange personal information about services for my child and family receive. **Signature**_____
__ I DO NOT give consent for any information to be shared between Shenandoah Valley Early Childhood Education Program and my local Department of Social Services.

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 Specialist
59 John Lewis Rd. Suite 101
Fishersville, VA 22939
Phone: 540-245-5162 ext. 109 Fax: 540-245-5064

SVHS/EHS Office Use Only:

__A-1	__CCC	__B
__A-2	__DE	__EE
__A-3		__H
		__HB
		__WH

Staff signature_____
___Face-to-face ___Phone:reason_____

Approved January 2016