

**General**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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 #:   |               | <input type="checkbox"/> cell | <input type="checkbox"/> work | <input type="checkbox"/> home |
| Alternate Telephone #: |               | <input type="checkbox"/> cell | <input type="checkbox"/> work | <input type="checkbox"/> home |
| Emergency Contact #:   |               | <input type="checkbox"/> cell | <input type="checkbox"/> work | <input type="checkbox"/> 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 |
|---|----------------------------|---|--|-------------------------|
| <b>Primary Adult:</b><br>Has legal custody of applicant: <input type="checkbox"/> yes <input type="checkbox"/> no<br>If no, please state how child is in your care: _____   |                            | <input type="checkbox"/> birth parent<br><input type="checkbox"/> step parent, married<br><input type="checkbox"/> parent's partner, unmarried<br><input type="checkbox"/> foster or adoptive parent<br><input type="checkbox"/> legal guardian<br><input type="checkbox"/> unofficial guardian | <input type="checkbox"/> full time (35 hrs. or more a week)<br><input type="checkbox"/> part time (under 35 hrs. a week)<br><input type="checkbox"/> retired or disabled<br><input type="checkbox"/> training or school<br><input type="checkbox"/> unemployed<br><input type="checkbox"/> seasonally employed |                         |
| <b>Secondary Adult:</b><br>Has legal custody of applicant: <input type="checkbox"/> yes <input type="checkbox"/> no<br>If no, please state how child is in your care: _____ |                            | <input type="checkbox"/> birth parent<br><input type="checkbox"/> step parent, married<br><input type="checkbox"/> parent's partner, unmarried<br><input type="checkbox"/> foster or adoptive parent<br><input type="checkbox"/> legal guardian<br><input type="checkbox"/> unofficial guardian | <input type="checkbox"/> full time (35 hrs. or more a week)<br><input type="checkbox"/> part time (under 35 hrs. a week)<br><input type="checkbox"/> retired or disabled<br><input type="checkbox"/> training or school<br><input type="checkbox"/> unemployed<br><input type="checkbox"/> 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  Other  
 Bi or Multi-Racial  American Indian/Alaska Native

Ethnicity of Child:  
 Aleut  Black(Non-Hispanic BL)  Cuban  Chinese  American Indian  
 Korean  Eskimo  Samoan  Pacific/Asian Islander  Vietnamese  
 Japanese  Filipino  Japanese  Guamanian  Hawaiian  Hispanic  
 Other  Central American  Mexican/Chicano  Puerto Rican  White

**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) |
|--|------------------------------------|--|------------------------------|
|  |                                    | <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice a month<br><input type="checkbox"/> yearly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> quarterly |                              |
|  |                                    | <input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice a month<br><input type="checkbox"/> yearly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> 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.*

- |   |  |
|---|--|
| <input type="checkbox"/> Child's parents did not marry  | <input type="checkbox"/> Parent(s) did not finish high school (U.S. or native country) |
| <input type="checkbox"/> Child's parents are divorced/separated   | <input type="checkbox"/> Parent(s) has limited reading skills in primary language      |
| <input type="checkbox"/> Child has no contact with one or both parents  | <input type="checkbox"/> Parent(s) has limited English proficiency                     |
| <input type="checkbox"/> Child does not live with his/her parents   | <input type="checkbox"/> Child has limited English proficiency                         |
| <input type="checkbox"/> Child or siblings have been removed from the home  | <input type="checkbox"/> Parental substance abuse history                              |
| <input type="checkbox"/> Child is was in foster care  | <input type="checkbox"/> Domestic violence in the home                                 |
| <input type="checkbox"/> Deceased parent (of child)   | <input type="checkbox"/> Child has been abused (physically, sexually or emotionally)   |
| <input type="checkbox"/> Incarcerated parent(s)   | <input type="checkbox"/> Child or family is in counseling                              |
| <input type="checkbox"/> Parent absent from the home: works out of town, long term hospitalization, or military service | <input type="checkbox"/> Teen mother or father at child's birth (under 20 yrs. of age) |
| <input type="checkbox"/> Both/all parents/legal guardians unemployed  | <input type="checkbox"/> Child weighed less than 5 lbs at birth                        |
| <input type="checkbox"/> Family has moved more than 2 times within the last year  | <input type="checkbox"/> Child has a disability  |
| <input type="checkbox"/> Housing Concerns: overcrowded, needs major repairs, lack of heat, etc.                         | <input type="checkbox"/> Sibling has a disability                                      |
| <input type="checkbox"/> Homeless family (lack a fixed, permanent residency)  | <input type="checkbox"/> Parent has a disability                                       |
| <input type="checkbox"/> Family has nutritional needs   | <input type="checkbox"/> Child does not have medical insurance                         |
| <input type="checkbox"/> No drivers license holder in household   | <input type="checkbox"/> Parent has a long term or chronic illness                     |
| <input type="checkbox"/> Family is receiving WIC  | <input type="checkbox"/> Child does not have a regular pediatrician and/or dentist     |
| <input type="checkbox"/> No other preschool services available for this child. State why:                               | <input type="checkbox"/> 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**

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-C                       BB                       B  
 A-S                       CC                       EE  
 A-W                       DE                       H  
 CW                         HB  
 LL                         WH  
 Staff signature \_\_\_\_\_  
 Face-to-face                       Phone:reason \_\_\_\_\_