

Preschool & Child Care for Your Family

Enrollment opportunities and requirements vary by child care/preschool site



**Champlain Valley Head Start provides
high quality early child care and preschool programs
for children ages 0-5 Years.**

Applying Is Easy:

To get started, please fill out the attached application and provide verification of your income using **one** of the following documents.

- **Reach Up/RUFA documentation**
- **Supplemental Security Income (SSI) documentation**
- **Foster Care Custody Order/Agreement**
- **A copy of a pay stub, or a tax return, or W-2, unemployment check stub, or VRRP documentation**
- **A letter stating that you are homeless** (If this applies, you will receive an additional form to fill out.)

Once you have gathered the needed materials and filled out the forms, please return them to our office in the enclosed self-addressed, postage paid envelope, or using your envelope/stamp, mail to: *Champlain Valley Head Start, 19 Roosevelt Highway, Suite 305, Colchester, VT 05446.*

Questions?

Contact us at 651-4180, ext. 205

Or apply@cvoeo.org



A Program of Champlain Valley Office of Economic Opportunity

Family Information

Housing*

Can you and your child go the SAME PLACE, EVERY NIGHT to sleep in a SAFE & SUFFICIENT SPACE?

Yes No

Does your family have stable long-term housing (please check 'no' if you are currently staying in a shelter or transitional housing)?

Yes No

Language*

At home, our family speaks (please list primary language):

Parent / Guardian 1 Information

First Name	Last Name	Date of Birth	
Relationship to Child: <input type="checkbox"/> Mother / Father <input type="checkbox"/> Foster Mother / Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Living Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code
Phone #1: _____	Type of Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message		
Phone #2: _____	Type of Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message		
Phone #3: _____	Type of Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message		
Email: _____	Directions to home: _____		

Employment

U.S. Military Status:

I am currently a member of the U.S. Military

I am a former member of the U.S. Military (Veteran)

I am not/have never been a member of the U.S. Military

Education*

Job Training / School Status:

Not in job training or school

In job training (please provide the name of the program): _____

In school (please provide the name of the school or learning program): _____

Have you received a grant or scholarship for your school within the last 12 months?

Yes No

Employment Status:

Employed – Full-time

Employed – Part-time

Employed – Seasonal

Unemployed

Retired

Disabled

Education Level:

Less than high school graduate

High school graduate or GED

Some college, vocational school, or Associate's Degree

Bachelor's Degree or advanced degree

Language Information*

The language(s) that I speak is(are):

<input type="checkbox"/> Arabic	<input type="checkbox"/> Lingala
<input type="checkbox"/> Bhutanese	<input type="checkbox"/> Maay Maay
<input type="checkbox"/> Bosnian	<input type="checkbox"/> Mandarin
<input type="checkbox"/> Burmese	<input type="checkbox"/> Nepali
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Somali
<input type="checkbox"/> English	<input type="checkbox"/> Spanish
<input type="checkbox"/> French	<input type="checkbox"/> Swahili
<input type="checkbox"/> Karen	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Kirundi	<input type="checkbox"/> Other: _____

If English is not your primary language, please mark the choice below that best describes your interpretative needs:

I do not need an interpreter

I would like an interpreter to help complete paperwork only

I would like an interpreter for most/all communication

Cultural Information

Please note, this cultural information will not impact your child's enrollment in the program. This information will not be shared outside of Champlain Valley Office of Economic Opportunity (CVOEO), of which CVHS is a program.

Were you born in the U.S.?

Yes No

Are you a current or former refugee?

Yes No

Household Information

Please list all persons living in the home with the family who were not listed previously:

Person #1

Name:	Relationship to Child: <input type="checkbox"/> Aunt / Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Step-parent (legally married to child's parent/guardian) <input type="checkbox"/> Unrelated child <input type="checkbox"/> Unrelated adult (including non-married partners of child's parent/guardian)
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Person #2

Name:	Relationship to Child: <input type="checkbox"/> Aunt / Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Step-parent (legally married to child's parent/guardian) <input type="checkbox"/> Unrelated child <input type="checkbox"/> Unrelated adult (including non-married partners of child's parent/guardian)
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Person #3

Name:	Relationship to Child: <input type="checkbox"/> Aunt / Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Step-parent (legally married to child's parent/guardian) <input type="checkbox"/> Unrelated child <input type="checkbox"/> Unrelated adult (including non-married partners of child's parent/guardian)
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Person #4

Name:	Relationship to Child: <input type="checkbox"/> Aunt / Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Step-parent (legally married to child's parent/guardian) <input type="checkbox"/> Unrelated child <input type="checkbox"/> Unrelated adult (including non-married partners of child's parent/guardian)
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Person #5

Name:	Relationship to Child: <input type="checkbox"/> Aunt / Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Step-parent (legally married to child's parent/guardian) <input type="checkbox"/> Unrelated child <input type="checkbox"/> Unrelated adult (including non-married partners of child's parent/guardian)
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Person #6

Name:	Relationship to Child: <input type="checkbox"/> Aunt / Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Step-parent (legally married to child's parent/guardian) <input type="checkbox"/> Unrelated child <input type="checkbox"/> Unrelated adult (including non-married partners of child's parent/guardian)
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Eligibility*

Please answer the following questions. If you answer "Yes" to any of the questions, your family may be eligible to receive Head Start services.

Is this child currently in foster care (in the custody of the State of Vermont)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your family currently experiencing homelessness (Staying in a shelter, hotel, car, campground, transitional housing unit, or sharing the housing of others due to loss of housing or economic hardship)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your family <u>currently</u> receiving Reach Up?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your family <u>currently</u> receiving Supplemental Security Income (SSI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Household Income*

If you answered 'No' to all of the questions above, please complete the following section. For each type of income that your family received within the last 12 months, you will need to supply documentation.

Parent/Guardian 1 Name: _____

Yes	No	Type of Income	Have you received this income for all of the last 12 months?		Gross Amount (before taxes)	How often do you receive this income? (annually, monthly, two times a month, every two weeks, weekly)
			Yes	No (# of Months)		
<input type="checkbox"/>	<input type="checkbox"/>	Child Support	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Reach Up (not currently receiving)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rental Income	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Scholarships/Educational Grants	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Self-Employment Income	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefit	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Veterans Benefits	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wages (Job 1)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wages (Job 2)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wages (Job 3)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____

Parent/Guardian 2 Name (if living in the household): _____

Yes	No	Type of Income	Have you received this income for all of the last 12 months?		Gross Amount (before taxes)	How often do you receive this income? (annually, monthly, two times a month, every two weeks, weekly)
			Yes	No (# of Months)		
<input type="checkbox"/>	<input type="checkbox"/>	Child Support	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Reach Up (not current receiving)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rental Income	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Scholarships/Educational Grants	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Self-Employment Income	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefit	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Veterans Benefits	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wages (Job 1)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wages (Job 2)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wages (Job 3)	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/> _____	\$ _____	_____

Immediate Family Needs

Please use this space to tell us about any current circumstances affecting your family that may impact your need for immediate school and/or child care for your child.

Outreach

Where did you hear about Champlain Valley Head Start?
(Please check one)

- | | |
|--|--|
| <input type="checkbox"/> Brochure Poster | <input type="checkbox"/> DCF (Family Services Division) |
| <input type="checkbox"/> CVHS Teacher / Home Visitor | <input type="checkbox"/> Friend / Family Member |
| <input type="checkbox"/> CVHS Collaborative Partner | <input type="checkbox"/> Newspaper/Magazine Ad |
| <input type="checkbox"/> CVHS Social Media | <input type="checkbox"/> Service Provider (such as Reach Up, VNA, WIC) |
| <input type="checkbox"/> CVHS Website | <input type="checkbox"/> Other (please specify): _____ |

Parent / Guardian Signature

This application signifies the family's desire to enroll the child in the Early Head Start or Head Start program. Following completion of this application, the application will be processed and Champlain Valley Head Start will notify the family as to whether the child has been enrolled in the program, and the starting date for services.

By signing below, I, the parent/guardian, indicate that:

- I intend to enroll my child in Early Head Start or Head Start if my child is accepted into the program.
- I agree to comply with the rules and regulations of the program.
- I certify that the information I have provided on and in support of this application is accurate and truthful to the best of my knowledge. I understand that intentionally providing false, inaccurate, or incomplete information may result in a loss of my family's eligibility to participate in the program.
- I consent to have my child participate in all health and developmental screenings or non-invasive exams (including, but not limited to: hearing and vision screenings, heights and weights, visual oral health screening) conducted by Champlain Valley Head Start staff, consultants, collaborative partners or others working in conjunction with Champlain Valley Head Start, to help assure compliance with all federal and state regulations. These may take place outside of the classroom. All screening and exam results and recommendations will be shared with me by the program.
- I consent to have my child receive his/her special education and/or mental health services, as outlined in his/her IEP, IFSP/One Plan, and/or treatment plan, during Head Start classroom time. I understand that these services may be provided by special educators, including speech/language pathologists, occupational therapists, physical therapists, and individual assistants, or early childhood mental health professionals and may take place outside of the classroom.
- I understand that the Head Start program utilizes the services of early childhood mental health consultants in order to better provide quality education services by increasing the social and emotional well-being of children. I consent to have my child participate in the services provided by the early childhood mental health consultants. The program will notify me in advance of any services provided individually to my child.

Was this application completed with the help of another person other than the parent/guardian indicated below?

No Yes (please provide name): _____ Organization (if applicable): _____

Parent / Guardian Signature: _____ **Date:** _____

Release of Information

Head Start and Early Head Start (HS/EHS) are national programs. Federal regulations require that we obtain certain information in order to determine eligibility for the program and to provide services. In order to best serve your child and family, we sometimes need to share information, in verbal, written, or electronic format, with other agencies. Except as allowed in this authorization and release, Champlain Valley Head Start will not communicate or disseminate any confidential child or family information to organizations or entities outside the organization.

By signing this release, I authorize Champlain Valley Head Start to exchange information with, release information to, and/or obtain information from, the following organizations (you must check all boxes that apply if you would like us to be able to speak/share information with these organizations):

- The local school district and/or CIS agency responsible for comprehensive evaluation and development of an IFSP or IEP (if needed) for the purpose of:
 - Obtaining documentation of my child's comprehensive evaluation and/or IFSP or IEP in order to provide individualized education services to my child
 - Coordinating educational services for my child
- The local District Office of the Economic Services Division that administers TANF (Reach Up) benefits for the purpose of:
 - Obtaining TANF documentation to determine eligibility for the Head Start program
 - Coordinating the family goal setting process
 - Contacting my family if direct communication methods fail
- The local Community Care Support Agency that administers the Child Care Financial Assistance program for the purpose of:
 - Obtaining Child Care Financial Assistance documentation to determine eligibility for specific Head Start program options.
 - Coordinating the enrollment of my child in Head Start and/or its collaborative partner sites
- The local District Office of the Family Services Division for the purpose of:
 - Obtaining documentation to determine eligibility for the Head Start program
 - Coordinating family safety/support services
- Other (please specify): _____

Use of Photographs / Video

Yes **No** I give my permission to Champlain Valley Head Start or its funders / partners to use photos and/or video of my child and/or family with the understanding that my child/family will not be identified by name. Photos or video may be used in newsletters, websites, social media, brochures or other recruitment / outreach / fundraising / promotional materials or reports.

Authorized Representative (Optional)

If you would like to give permission to someone to speak with us on your behalf, please fill out this section.

By filling out the Authorized Representative section and signing below you agree to the following:

- I understand that I am not required to have an Authorized Representative
- I give CVHS and the Authorized Representative permission to communicate with each other and share information about my family and myself for the purposes of applying for the Head Start program and coordinating services for my family.
- I may revoke this authorization at any time by calling (802) 651-4180 x204 and informing the Enrollment Manager that I am revoking this authorization.

Name of Authorized Representative:	Representative's Phone Number:
Authorized Representative's Relationship to You:	Authorized Representative's Organization Name (if applicable):

Child's Information

Child's Legal Name:	Child's Date of Birth:
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Parent/ Legal Guardian's Name (Printed): _____

Parent / Legal Guardian's Signature: _____ Date: _____



Release of Health and Screening Information

Head Start and Early Head Start (HS/EHS) are national programs. Federal regulations require that these programs obtain documentation to facilitate up to date health requirements for children and pregnant women and any follow up care needed.

Except as allowed in this authorization and release, CVHS will not communicate or disseminate any confidential child or family information to organizations or entities outside of CVHS and our collaborative partner child care and school sites.

I hereby authorize Champlain Valley Head Start to:

- Obtain the following information from health care providers and state registries for the below named child/pregnant woman:
 - medical and dental records (including follow-up care with specialists)
 - lead and hemoglobin test results
 - immunization records
 - developmental screening results
 - prenatal and postpartum documentation for pregnant women enrolled in EHS

The above information may be either electronic, written or verbal and will be released to:
CVHS Health or Special Needs Coordinator, Nurse Consultant or Tooth Tutor
431 Pine Street, Suite 212, Burlington, VT 05401
(802) 651-4180 X215

- Share and discuss results of my child's Head Start screenings (vision, hearing, growth, oral health, and developmental) and health records with my child's health care providers and/or state registries or CVHS collaborative partners in order to provide/support services for my child/family.
- Share my child's growth assessment, enrollment and oral health status with WIC and its Public Health Dental Hygienists. If my child is transitioning to public school: share my child's oral health status with the public school Tooth Tutor.

I acknowledge that:

- I may revoke this consent at any time (by contacting CVHS at the address or telephone number above) except to the extent that action has been taken in reliance on it before I revoked it.
- This consent will expire on December 31, 2021.

Authorization is for the following child or pregnant woman:

_____ (Child's Legal Name or Pregnant Woman's Legal Name)

_____ (Child's or Pregnant Woman's DOB)

I am the: Parent Legal Guardian DCF Authorized Representative: of the above-named child;

Or

Pregnant Woman

Printed Name: _____

Signature: _____ Date: _____

Child's Health Information

Child's Legal Name	Date of Birth
Does your child have a doctor? <input type="checkbox"/> No <input type="checkbox"/> Yes, Doctor's Name: _____	Phone
Does your child have a dentist? * <input type="checkbox"/> No <input type="checkbox"/> Yes, Dentist's Name: _____	Phone
Does your child have any health conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list: _____	Symptoms
Does your child take any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list: _____	Medication needed on site? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have any allergies (including medications, food, bee stings, etc.)? <input type="checkbox"/> No Known Allergies <input type="checkbox"/> Yes, please list: _____	Symptoms

Permission to Pick Up / Permission to Transport

By signing on the Parent/Guardian signature line below, I give my permission for my child to be transported in the event of an emergency. Additionally, I give my permission for my child to be released to the following people for the purposes of pick-up and/or transportation to/from CVHS activity sites. (Include the child's other parent and other family members who may be likely to transport the child.) The parent/guardian understands that his/her child will only be released to persons identified on the following list. Anyone who is unknown to CVHS staff must show identification. I give my permission for my child to be transported to and from CVHS activities by any transportation service with whom CVHS may contract for transportation of children in the CVHS program, and to release the name and address of my child to transportation services contracted by CVHS for the purpose of CVHS activities.

In the event of an emergency, I authorize the staff or collaborative partners of Champlain Valley Head Start to seek any necessary treatment or emergency medical care for my child.

Emergency Contacts: *Vermont State Early Childhood Program Licensing Regulations require that at least two (2) emergency contacts, other than the legal parent(s)/guardian(s), be identified.* Emergency Contact People must be able to transport the child in the event of an emergency if the CVHS parent or legal guardian cannot be reached. Emergency contacts must be aware they are designated as such. Emergency contacts unknown to CVHS staff must produce identification before a child is released.

Primary Parent/Guardian Name	First Phone #	Second Phone #
Secondary Parent/Guardian Name	First Phone #	Second Phone #


Emergency Contact #1		Emergency Contact #2		Emergency Contact #3	
Name		Name		Name	
Relationship to Child		Relationship to Child		Relationship to Child	
Phone #	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Phone #	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Phone #	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Address		Address		Address	

Other people authorized to pick up my child are:

Name	Name	Name
Relationship to Child	Relationship to Child	Relationship to Child

Parent / Guardian Signature: _____ **Date:** _____

Instructions: Please use the Choice # column to select your 1st, 2nd, and 3rd choice options by indicating 1, 2, and 3 in the appropriate selection box. Please indicate if you have transportation to this site in second column.

<p>Choice</p> <p>Do you have transportation to this site? Y/N</p>	 <p>CHAMPLAIN VALLEY Head Start</p> <p>Anticipated Program Options List</p> <p>2020 - 2021 (Updated 2-11-20)</p>		<p>Ages Served</p>				<p>Town</p>	<p>Days</p>	<p>Times</p>	<p>Session Year</p>	<p>Town Resident</p>	<p>Act 166 Approved</p>	<p>Child Care Financial Assistance</p>

Address	Choice #	Transportation	Pregnant Women	Birth - 1 yr	1 yr - 3 yrs	3 yrs - 4 yrs	4 yrs only	Town	Days	Times	Session Year	Town Resident	Act 166 Approved	Child Care Financial Assistance
Addression County (802) 388-9881 87 Rivers Bend Road, New Haven, VT 05472														
Early Head Start Home Visiting Program: Throughout Addison County	X	X	X	X				All Towns	1 Visit/Week	N/A	Full Year	N/A	N/A	N/A
Otter Creek Child Center: 150 Weybridge Street		X	X					Middlebury	Mon-Fri	7:30am-5:30pm	Full Year	NO	N/A	YES
Addison County Early Learning Center Early Head Start: 87 Rivers Bend Road			X					New Haven	Mon-Fri	8:00am-2:00pm	Full Year	NO	N/A	NO
Addison County Early Learning Center Head Start: 87 Rivers Bend Road			X					New Haven	Mon-Fri	8:00am-2:00pm	Sept - June	NO	YES	NO
Chittenden County (802) 872-2819 19 Roosevelt Hwy., Colchester, VT 05446														
Early Head Start Home Visiting Program: Throughout Chittenden County	X	X	X	X				All Towns	1 Visit/Week	N/A	Full Year	N/A	N/A	N/A
Burlington Children's Space Early Head Start: 241 N. Winoski Ave.		X	X					Burlington	Mon-Fri	8:30am-2:30pm	Full Year	NO	N/A	YES
Franklin Square Early Learning Center: 61 Red Maple Lane			X					Burlington	Mon-Fri	8:30am-5:30pm	Sept - June	NO	YES	NO
King Street Center Early Head Start: 87 King Street			X					Burlington	Mon-Fri	7:30am-5:30pm	Full Year	YES	YES	YES
King Street Center Head Start: 87 King Street			X					Burlington	Mon-Fri	7:30am-5:30pm	Full Year	YES	YES	YES
Riverside Early Learning Center Early Head Start: 669 Riverside Ave.			X					Burlington	Mon-Fri	8:30am-2:30pm	Full Year	NO	N/A	NO
Riverside Early Learning Center Head Start: 669 Riverside Ave.			X					Burlington	Mon-Fri	8:30am-2:30pm	Sept - June	NO	YES	NO
Sara Holbrook Community Center Early Head Start: 66 North Ave.			X					Burlington	Mon-Fri	8:00am-4:30pm	Full Year	NO	N/A	YES
Sara Holbrook Community Center Head Start: 66 North Ave.			X					Burlington	Mon-Fri	8:00am-4:30pm	Full Year	NO	YES	YES
Milton Elementary School: 42 Herrick Avenue							X	Milton	Mon-Fri	8:45am-3:15pm	Sept - June	YES	YES	NO
Milton Family Community Center: 23 Villmaire Lane			X	X				Milton	Mon-Fri	7:30am-5:30pm	Full Year	NO	N/A	YES
JFK Elementary School ELC Morning: 70 Normand Street			X	X				Winooski	Mon-Fri	7:30am-11:00am	Sept - June	YES	YES	NO
JFK Elementary School ELC Afternoon: 70 Normand Street			X	X				Winooski	Mon-Fri	11:30am-3:00pm	Sept - June	YES	YES	NO
JFK Elementary School Morning: 70 Normand Street			X	X				Winooski	Mon-Th	7:30am-11:00am	Sept - June	YES	YES	NO
JFK Elementary School Afternoon: 70 Normand Street			X	X				Winooski	Mon-Th	11:30am-3:00pm	Sept - June	YES	YES	NO
Franklin & Grand Isle Counties (802) 524-5876 5 Lemnah Drive, St. Albans, VT 05478														
Early Head Start Home Visiting Program: Throughout Franklin County	X	X	X	X				All Towns	1 Visit/Week	N/A	Full Year	N/A	N/A	N/A
St. Albans Early Learning Center: 27 Church Street			X					St. Albans City	Mon-Fri	8:30am-2:30pm	Sept - June	NO	YES	NO

* = Transportation currently provided by the school district (subject to change)

We will make every attempt to place your child within your preferred option based on program availability, eligibility, and selection criteria.