

# APPLICATION EXPECTANT MOTHER

## EARLY HEAD START PROGRAM

UPDATED FEBRUARY 2021



A Program of Champlain Valley Office of Economic Opportunity

APPLICANT'S INFORMATION			
FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH
LIVING ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE
PHONE #1:	<input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK	NOTES:	
PHONE #2:	<input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK	NOTES:	
EMAIL:			

PRIOR PARTICIPATION IN CVHS
Do you have children who have ever participated in the CVHS Head Start or Early Head Start? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide the child's name:

LANGUAGE
The language(s) that I speak is (are):
<input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> Nepali
<input type="checkbox"/> Bhutanese <input type="checkbox"/> Karen <input type="checkbox"/> Somali
<input type="checkbox"/> Bosnian <input type="checkbox"/> Kirundi <input type="checkbox"/> Spanish
<input type="checkbox"/> Burmese <input type="checkbox"/> Maay Maay <input type="checkbox"/> Swahili
<input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Vietnamese
<input type="checkbox"/> English <input type="checkbox"/> Other: _____
If English is not your primary language, please mark the choice below that best describes your interpretative needs:
<input type="checkbox"/> I do not need an interpreter
<input type="checkbox"/> I would like an interpreter to help complete paperwork only
<input type="checkbox"/> I would like an interpreter for most/all communication

RACE & ETHNICITY	
<b>Race</b> (check all that apply)	<b>Ethnicity</b> (check one)
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Hispanic/Latino Origin
<input type="checkbox"/> Asian	<input type="checkbox"/> Non-Hispanic/Non-Latino Origin
<input type="checkbox"/> Black / African American	
<input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> White	
<input type="checkbox"/> Other (please specify):	

CULTURAL INFORMATION
Please note, this cultural information <b>will not</b> impact your enrollment in the program. This information <b>will not</b> be shared outside of Champlain Valley Office of Economic Opportunity (CVOEO), of which CVHS is a program.
Were you born in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a current or former refugee? <input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYMENT
<b>U.S. Military Status</b>
<input type="checkbox"/> I am currently a member of the U.S. Military
<input type="checkbox"/> I am a former member of the U.S. Military (Veteran)
<input type="checkbox"/> I am not/have never been a member of the U.S. Military
<b>Employment Status</b>
<input type="checkbox"/> Employed: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
<input type="checkbox"/> Employed Seasonally
<input type="checkbox"/> Unemployed
<input type="checkbox"/> Retired
<input type="checkbox"/> Disabled

EDUCATION
<b>Job Training/School Status</b>
<input type="checkbox"/> Not in job training or school
<input type="checkbox"/> In job training (please provide the name of the program): _____
<input type="checkbox"/> In school (please provide the name of the school or program): _____
Have you received a grant or scholarship for your school within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Education Level</b>
<input type="checkbox"/> Less than high school graduate
<input type="checkbox"/> High school graduate or GED
<input type="checkbox"/> Some college, vocational school, or Associate's Degree
<input type="checkbox"/> Bachelor's Degree or advanced degree

HEALTH INSURANCE
<b>Do you have health insurance?</b>
<input type="checkbox"/> No
<input type="checkbox"/> Yes, please check type:
<input type="checkbox"/> Medicaid / Dr. Dynasaur
<input type="checkbox"/> Private
<input type="checkbox"/> Other (please specify):
Applicant's Medicaid No. (if applicable):

# APPLICATION Family Information

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## FAMILY HOUSING & LANGUAGE

**HOUSING** Can your family go the SAME PLACE, EVERY NIGHT to sleep in a SAFE & SUFFICIENT SPACE?  Yes  No  
 Does your family have stable long-term housing? (check no if you are currently staying in a shelter/ transitional housing)  Yes  No

**LANGUAGE** The primary language our family speaks at home is:

## SECONDARY PARENT

FIRST NAME	LAST NAME		DATE OF BIRTH	GENDER
RELATIONSHIP TO CHILD:				<input type="checkbox"/> MALE
<input type="checkbox"/> FATHER <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER:				<input type="checkbox"/> FEMALE
RELATIONSHIP TO APPLICANT:				<input type="checkbox"/> OTHER
<input type="checkbox"/> MARRIED TO APPLICANT <input type="checkbox"/> BIOLOGICAL PARENT, NOT MARRIED <input type="checkbox"/> BIOLOGICAL PARENT NOT LIVING IN HOUSEHOLD <input type="checkbox"/> LIVING IN HOUSEHOLD				
LIVING ADDRESS	CITY	STATE	ZIP CODE	
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE	
PHONE #1:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL	<input type="checkbox"/> WORK	NOTES:
PHONE #2:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL	<input type="checkbox"/> WORK	NOTES:
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

**Employment Status**

Employed Full-time  Unemployed  
 Employed Part-time  Retired  
 Employed Seasonally  Disabled

## 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 program): \_\_\_\_\_

Have you received a grant or scholarship for your school within the last 12 months?  Yes  No

**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

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 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

# APPLICATION Household Information

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GUARDIAN'S INFORMATION			
<b>FOR MINOR EXPECTANT MOTHERS ONLY. If the applicant is a minor, please complete this section.</b>			
GUARDIAN'S NAME			GUARDIAN'S DATE OF BIRTH
LIVING ADDRESS	CITY	STATE	ZIP CODE
PHONE #1:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL	<input type="checkbox"/> WORK
PHONE #2:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL	<input type="checkbox"/> WORK
NOTES:			

HOUSEHOLD INFORMATION	
<b>Please list all persons living in the home with the Expectant Mother who were NOT listed previously:</b>	
<b>NAME OF PERSON 1:</b>	<b>RELATIONSHIP TO APPLICANT:</b>
DATE OF BIRTH	<input type="checkbox"/> Parent <input type="checkbox"/> Unrelated child or adult
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	<input type="checkbox"/> Child <input type="checkbox"/> Grandparent
	<input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling
	<input type="checkbox"/> Cousin <input type="checkbox"/> Spouse
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>NAME OF PERSON 2:</b>	<b>RELATIONSHIP TO APPLICANT:</b>
DATE OF BIRTH	<input type="checkbox"/> Parent <input type="checkbox"/> Unrelated child or adult
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	<input type="checkbox"/> Child <input type="checkbox"/> Grandparent
	<input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling
	<input type="checkbox"/> Cousin <input type="checkbox"/> Spouse
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>NAME OF PERSON 3:</b>	<b>RELATIONSHIP TO APPLICANT:</b>
DATE OF BIRTH	<input type="checkbox"/> Parent <input type="checkbox"/> Unrelated child or adult
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	<input type="checkbox"/> Child <input type="checkbox"/> Grandparent
	<input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling
	<input type="checkbox"/> Cousin <input type="checkbox"/> Spouse
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>NAME OF PERSON 4:</b>	<b>RELATIONSHIP TO APPLICANT:</b>
DATE OF BIRTH	<input type="checkbox"/> Parent <input type="checkbox"/> Unrelated child or adult
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	<input type="checkbox"/> Child <input type="checkbox"/> Grandparent
	<input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling
	<input type="checkbox"/> Cousin <input type="checkbox"/> Spouse
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>NAME OF PERSON 5:</b>	<b>RELATIONSHIP TO APPLICANT:</b>
DATE OF BIRTH	<input type="checkbox"/> Parent <input type="checkbox"/> Unrelated child or adult
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	<input type="checkbox"/> Child <input type="checkbox"/> Grandparent
	<input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Sibling
	<input type="checkbox"/> Cousin <input type="checkbox"/> Spouse
Does this person currently receive Supplemental Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

# APPLICATION Eligibility/Household Income

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### 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 applicant 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 currently receiving Reach Up?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your family currently 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.

### APPLICANT

NAME OF APPLICANT

Type of Income (check all that apply)	Have you received this income for all of the last 12 months?	How often do you receive this income?	Gross Amount (before taxes)
<input type="checkbox"/> Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Reach Up (not currently receiving)	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Scholarships/Educational Grants	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Self-Employment Income	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Social Security Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Wages: Job 1	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Wages: Job 2	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Wages: Job 3	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____

### SECONDARY PARENT

NAME OF SECONDARY PARENT (IF LIVING IN THE HOUSEHOLD)

Type of Income (check all that apply)	Have you received this income for all of the last 12 months?	How often do you receive this income?	Gross Amount (before taxes)
<input type="checkbox"/> Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Reach Up (not currently receiving)	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Scholarships/Educational Grants	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Self-Employment Income	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Social Security Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Wages: Job 1	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Wages: Job 2	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Wages: Job 3	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____
<input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No: _____ mos.	<input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly	\$ _____

# APPLICATION Additional Information

## EARLY HEAD START PROGRAM

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### IMMEDIATE FAMILY NEEDS

Please use this space to tell us about any current circumstances affecting your family.

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### OUTREACH

Where did you hear about Champlain Valley Head Start (CVHS)? 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): _____                 |

### APPLICANT (OR PARENT/GUARDIAN IF MINOR) SIGNATURE

This application signifies the applicant's desire to enroll in the Expectant Mother program. Following completion of this application, the application will be processed and Champlain Valley Head Start will notify the applicant as to whether they have been enrolled in the program, and the starting date for services.

By signing below, I, the applicant, indicate that:

I intend to enroll in Early Head Start if I am 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.

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): \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# AUTHORIZATION & RELEASE

## EARLY HEAD START PROGRAM

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### RELEASE OF INFORMATION

Early Head Start (EHS) is a national program. 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 the expectant mother 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 expectant mother 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:

Yes  No **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 Early Head Start program
- Coordinating the family goal setting process
- Contacting my family if direct communication methods fail

Yes  No **The local District Office of the Family Services Division for the purpose of:**

- Obtaining documentation to determine eligibility for the Early Head Start program
- Coordinating family safety/support services

Yes  No **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 me and/or family with the understanding that my family and I 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)

### APPLICANT'S INFORMATION

APPLICANT'S LEGAL NAME

APPLICANT'S DATE OF BIRTH

**Applicant Signature** (or Parent/Guardian if Applicant is a Minor): \_\_\_\_\_ Date: \_\_\_\_\_

# HEALTH RELEASE

HEAD START & EARLY HEAD START PROGRAM

UPDATED MARCH 2021



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## RELEASE OF HEALTH & SCREENING INFORMATION

Early Head Start (EHS) is a national program. Federal regulations require that this program obtains documentation to facilitate up to date health requirements for pregnant women and any follow up care needed.

Except as allowed in this authorization and release, CVHS will not communicate or disseminate any confidential expectant mother or family information to organizations or entities outside of CVHS.

**I hereby authorize Champlain Valley Head Start to:**

**Obtain the following information from health care providers and state registries for the below named 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:

**Champlain Valley Head Start Health or Special Needs Coordinator, Nurse Consultant or Tooth Tutor**

**431 Pine Street, Suite 212**

**Burlington, VT 05401**

**(802) 651-4180 X215**

**Discuss results of my health records with my health care providers in order to provide/support services for me or my family.**

**Share my prenatal assessment, enrollment and oral health status with WIC and its Public Health Dental Hygienists.**

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, 2022.

## AUTHORIZATION IS FOR THE FOLLOWING CHILD OR PREGNANT WOMAN:

PREGNANT WOMAN'S LEGAL NAME	DATE OF BIRTH
I am the: <input type="checkbox"/> Pregnant Woman <input type="checkbox"/> Parent (If pregnant woman is a minor) <input type="checkbox"/> Legal Guardian (If pregnant woman is a minor) <input type="checkbox"/> DCF Authorized Representative of the above-named child	
PRINTED NAME	
<b>Signature:</b> _____ <b>Date:</b> _____	

# EMERGENCY

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APPLICANT'S HEALTH INFORMATION	
APPLICANT'S LEGAL NAME	DATE OF BIRTH
Do you have a primary care doctor? <input type="checkbox"/> No <input type="checkbox"/> Yes, <b>Doctor's Name:</b>	PHONE
Do you have a prenatal care provider? <input type="checkbox"/> No <input type="checkbox"/> Yes, <b>Doctor's Name:</b>	PHONE
Do you have a current dentist? <input type="checkbox"/> No <input type="checkbox"/> Yes, <b>Dentist's Name:</b>	PHONE
Do you have any health conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list conditions: Symptoms:	
Do you take any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list medications: Symptoms:	
Do you have any allergies (including medications, food, bee stings, etc.)? <input type="checkbox"/> No known allergies <input type="checkbox"/> Yes, please list: Symptoms:	
Is your pregnancy <b>high risk</b> as determined by a doctor or healthcare provider? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I don't know	EXPECTED DELIVERY DATE

PERMISSION TO PICK UP/PERMISSION TO TRANSPORT		
<p>I give my permission for the minor, <b>if applicable</b>, to be released to the following people for the purposes of pick-up and/or transportation to/from CVHS activity sites. (Include the minor's other parent/guardian and other family members who may be likely to transport the minor.) The parent/guardian understands that the minor 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 the minor 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.</p> <p>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.</p> <p><b>Emergency Contacts:</b> Emergency Contact People must be able to transport the expectant mother in the event of an emergency if the legal guardian cannot be reached. Emergency contacts must be aware they are designated as such.</p>		
<b>APPLICANT</b>	PHONE NUMBER	ALTERNATE PHONE NUMBER
<b>SECONDARY PARENT</b>	PHONE NUMBER	ALTERNATE PHONE NUMBER
EMERGENCY CONTACTS (must include 3 contacts other than applicant and secondary parent)		
FIRST CONTACT NAME	RELATIONSHIP TO APPLICANT	
PHONE <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	ADDRESS	
SECOND CONTACT NAME	RELATIONSHIP TO APPLICANT	
PHONE <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	AD	
<b>APPLICANT SIGNATURE</b>	PRINT NAME	DATE
<b>PARENT/GUARDIAN SIGNATURE</b> (If applicant is a minor)	PRINT NAME	DATE