# Pregnancy Services for your Family

# Apply today!

Now accepting applications for 2025-2026 school year

## How to apply:

### Fill out the attached Application

Or complete the online application at:
champlainvalleyheadstart.org/apply-now

### Provide documentation of your income from the last 12 months:

- W-2 form, Federal tax return - Form 1040, or Pay stubs
- Reach Up / RUFA
- 3SquaresVT/SNAP benefits
- Supplemental Security Income (SSI)
- Foster Care Custody Order / Agreement

*Income eligibility may apply.* Find more information at:
champlainvalleyheadstart.org/apply-now/are-you-eligible

### Submit the Application

- Email the Application and income documents to apply-cvhs@cvoeo.org
- Or mail or drop off the Application and copy of the income documents to our Burlington office:

  Champlain Valley Head Start
  255 South Champlain St, Suite 10
  Burlington, VT 05401


## Next steps:

Once the application is submitted, we will call you to confirm we have the required income documents.

### Questions?

Contact us with questions about eligibility or how to apply!

Or submit an Interest Form on our website.

**802-752-9397**
**apply-cvhs@cvoeo.org**
champlainvalleyheadstart.org

CHAMPLAIN VALLEY Head Start

cvoeo

# PREGNANCY SERVICES APPLICATION

EARLY HEAD START PROGRAM

*UPDATED JANUARY 2025*

CHAMPLAIN VALLEY Head Start
A Program of Champlain Valley Office of Economic Opportunity

## PREGNANT APPLICANT'S INFORMATION

| FIRST NAME | MIDDLE INITIAL | LAST NAME | DATE OF BIRTH |
|---|---|---|---|
| | | | |

NICKNAME/PREFERRED NAME

LIVING ADDRESS | CITY | STATE | ZIP CODE

MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE

PHONE #1: ☐ HOME ☐ CELL ☐ WORK NOTES:

PHONE #2: ☐ HOME ☐ CELL ☐ WORK NOTES:

EMAIL:

**WHEN IS YOUR BABY DUE?** DATE:

## LANGUAGE

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

- ☐ Arabic
- ☐ Bhutanese
- ☐ Bosnian
- ☐ Burmese
- ☐ Dari
- ☐ English
- ☐ French
- ☐ Karen
- ☐ Kirundi
- ☐ Lingala
- ☐ Maay Maay
- ☐ Mandarin
- ☐ Nepali
- ☐ Pashto
- ☐ Somali
- ☐ Spanish
- ☐ Swahili
- ☐ Vietnamese
- ☐ Other: _____

**Preferred language for interpreter**:

_____

**Preferred interpreter**:

_____

**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

## RACE & ETHNICITY

**Race** (check all that apply)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other (please specify):

_____

**Ethnicity** (check one)

- ☐ Hispanic/Latino Origin
- ☐ Non-Hispanic/ Non-Latino Origin

## SSI

Does this applicant receive SSI (Supplemental Security Income?)

☐ Yes ☐ No

## 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 ☐ Part-time
- ☐ Employed Seasonally
- ☐ Unemployed
- ☐ Retired
- ☐ 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):

_____

**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

# **APPLICATION** Family Information

EARLY HEAD START PROGRAM

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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 |
|---|---|---|
| | | |

PREFERRED NAME

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO CHILD:

☐ MARRIED TO APPLICANT ☐ BIOLOGICAL PARENT, NOT MARRIED ☐ BIOLOGICAL PARENT NOT LIVING IN HOUSEHOLD ☐ LIVING IN HOUSEHOLD

| LIVING ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

PHONE #1: ☐ HOME ☐ CELL ☐ WORK NOTES:

PHONE #2: ☐ HOME ☐ CELL ☐ 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
☐ Employed Part-time
☐ Employed Seasonally
☐ Unemployed
☐ Retired
☐ 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):

_____

**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)**:

☐ Arabic ☐ Bhutanese ☐ Bosnian ☐ Burmese ☐ Dari ☐ English ☐ French ☐ Karen ☐ Kirundi ☐ Lingala ☐ Maay Maay ☐ Mandarin ☐ Nepali ☐ Pashto ☐ Somali ☐ Spanish ☐ Swahili ☐ Vietnamese

☐ Other: _____

**Preferred language for interpreter**:

_____

**Preferred interpreter**:

_____

**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

## SSI

Does this parent receive SSI (Supplemental Security Income?)

☐ Yes ☐ No

# **APPLICATION** Household Information

EARLY HEAD START PROGRAM

*UPDATED JANUARY 2025*

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## GUARDIAN'S INFORMATION

**FOR PREGNANT APPLICANT UNDER THE AGE OF 18 ONLY. Please complete this section.**

| GUARDIAN'S NAME | | | GUARDIAN'S DATE OF BIRTH |
|---|---|---|---|
| LIVING ADDRESS | CITY | STATE | ZIP CODE |
| PHONE #1: | ☐ HOME ☐ CELL ☐ WORK | NOTES: | |
| PHONE #2: | ☐ HOME ☐ CELL ☐ WORK | NOTES: | |

## HOUSEHOLD INFORMATION

**Please list all persons living in the home with the Pregnant Applicant who were NOT listed previously:**

**NAME OF PERSON 1:**

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO APPLICANT:

☐ Parent ☐ Unrelated child or adult
☐ Child ☐ Grandparent
☐ Aunt/Uncle ☐ Sibling
☐ Cousin ☐ Spouse

Does this person currently receiveSupplemental Security Income (SSI)? ☐ Yes ☐ No

**NAME OF PERSON 2:**

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO APPLICANT:

☐ Parent ☐ Unrelated child or adult
☐ Child ☐ Grandparent
☐ Aunt/Uncle ☐ Sibling
☐ Cousin ☐ Spouse

Does this person currently receiveSupplemental Security Income (SSI)? ☐ Yes ☐ No

**NAME OF PERSON 3:**

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO APPLICANT:

☐ Parent ☐ Unrelated child or adult
☐ Child ☐ Grandparent
☐ Aunt/Uncle ☐ Sibling
☐ Cousin ☐ Spouse

Does this person currently receiveSupplemental Security Income (SSI)? ☐ Yes ☐ No

**NAME OF PERSON 4:**

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO APPLICANT:

☐ Parent ☐ Unrelated child or adult
☐ Child ☐ Grandparent
☐ Aunt/Uncle ☐ Sibling
☐ Cousin ☐ Spouse

Does this person currently receiveSupplemental Security Income (SSI)? ☐ Yes ☐ No

**NAME OF PERSON 5:**

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO APPLICANT:

☐ Parent ☐ Unrelated child or adult
☐ Child ☐ Grandparent
☐ Aunt/Uncle ☐ Sibling
☐ Cousin ☐ Spouse

Does this person currently receiveSupplemental Security Income (SSI)? ☐ Yes ☐ No

# **APPLICATION** Eligibility/Household Income

EARLY HEAD START PROGRAM

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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)? | ☐ Yes ☐ 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)? | ☐ Yes ☐ No |
| Is your family **currently** receiving Reach Up? | ☐ Yes ☐ No |
| Is your family **currently** receiving Supplemental Security Income (SSI)? | ☐ Yes ☐ No |
| Is this applicant **currently** receiving 3SquaresVT/SNAP benefits? | ☐ Yes ☐ No |

## CASE MANAGERS

**Please list NAME, PHONE, and EMAIL for case managers.**

Reach Up: _____

DCF: _____

USCRI: _____

Other: _____

## 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 PREGNANT 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) |
|---|---|---|---|
| ☐ Military Income | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Self-Employment Income | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Unemployment Compensation | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Wages: Job 1 | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Wages: Job 2 | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Wages: Job 3 | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Other: | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |

## SECONDAY PARENT

NAME OF PARENT/GUARDIAN (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) |
|---|---|---|---|
| ☐ Military Income | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Self-Employment Income | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Unemployment Compensation | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Wages: Job 1 | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Wages: Job 2 | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Wages: Job 3 | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |
| ☐ Other: | ☐ Yes ☐ No: _____mos. | ☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly | $_____ |

# **APPLICATION** Additional Information

EARLY HEAD START PROGRAM

*UPDATED JANUARY 2025*

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

## IMMEDIATE FAMILY NEEDS

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

_____

_____

_____

## PRIOR PARTICIPATION IN CVHS

Do you have children who have ever participated in the CVHS Head Start or Early Head Start? ☐ Yes ☐ No

If yes, please provide the child's name: _____

## OUTREACH

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

☐ Brochure Poster ☐ CVHS Website ☐ Friend/Family Member

☐ CVHS Teacher/Home Visitor ☐ DCF (Family Services Division) ☐ Newspaper/Magazine Ad

☐ CVHS Collaborative Partner ☐ CVHS Social Media

☐ Service Provider (such as Reach Up, VNA, WIC, please specify): _____

☐ Other (please specify): _____

## PROGRAM OPTIONS *(Please slect the programs you are interested in)*

| | |
|---|---|
| ☐ **HOME VISITING** | Weekly home visit with a trained family educator to support the expectant parent and family. Programs offered in Addison, Chittenden, Franklin and Grand Isle counties. |
| ☐ **FAMILY CONNECTIONS** | Expectant parent is included in play groups that meet twice a week. The baby will be enrolled in the program upon birth. Individual home visits are included twice a month with a trained family educator. Program is offered in Chittenden county. |
| | Do you have reliable transportation? ☐ Yes ☐ No<br>Which type? ☐ Public (bus) ☐ Car ☐ Walking ☐ Other: |

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

This application signifies the pregnant applicant's desire to enroll in the Pregnancy Services 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): _____

**Pregnant Applicant Signature**: _____ Date: _____

# AUTHORIZATION & RELEASE

EARLY HEAD START PROGRAM

*UPDATED JANUARY 2025*

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

## 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 pregnant applicant 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 pregnant applicant 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) and SNAP (3SquaresVT) benefits for the purpose of**:

- Obtaining TANF and/or SNAP 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

| PREGNANT APPLICANT'S LEGAL NAME | APPLICANT'S DATE OF BIRTH |
|---|---|

**Pregnant Applicant Signature** (or Parent/Guardian if Applicant is a Minor): _____ Date:_____

# HEALTH RELEASE

HEAD START & EARLY HEAD START PROGRAM

*UPDATED JANUARY 2025*

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

## 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 applicants and any follow up care needed.

Except as allowed in this authorization and release, CVHS will not communicate or disseminate any confidential pregnant applicant 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 applicant**:

- 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 applicant 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**
**255 South Champlain Street, Suite 10**
**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, 2026.

## AUTHORIZATION IS FOR THE FOLLOWING PREGNANT APPLICANT:

| PREGNANT APPLICANT'S LEGAL NAME | DATE OF BIRTH |
|---|---|
| | |

I am the:

- ☐ Pregnant Applicant
- ☐ Parent (If pregnant applicant is a minor)
- ☐ Legal Guardian (If pregnant applicant is a minor)
- ☐ DCF Authorized Representative of the above-named applicant

PRINTED NAME

**Signature**: _____ Date:_____

# EMERGENCY
EARLY HEAD START PROGRAM

*UPDATED JANUARY 2025*

CHAMPLAIN VALLEY Head Start
A Program of Champlain Valley Office of Economic Opportunity

## APPLICANT'S HEALTH INFORMATION

| PREGNANT APPLICANT'S LEGAL NAME | DATE OF BIRTH |
|---|---|
| Do you have a primary care doctor? ☐ No ☐ Yes, **Doctor's Name**: | PHONE |
| Do you have a prenatal care provider? ☐ No ☐ Yes, **Doctor's Name:** | PHONE |
| Do you h*ave a current dentist?* ☐ No ☐ Yes, **Dentist's Name**: | PHONE |

Do you have any health conditions? ☐ No ☐ Yes, please list conditions:
Symptoms:

Do you take any medications? ☐ No ☐ Yes, please list medications:
Symptoms:

Do you have any allergies (including medications, food, bee stings, etc.)? ☐ No known allergies ☐ Yes, please list:
Symptoms:

Is you pregnancy **high risk** as determined by a doctor or healthcare provider? ☐ No ☐ Yes ☐ I don't know

## HEALTH INSURANCE

**Do you have health insurance?** ☐ No ☐ Yes, please check type:
☐ Medicaid/Dr. Dynasaur ☐ Private ☐ Other: _____

Pregnant Applicant's Medicaid No. (if applicable):

## PERMISSION TO PICK UP/PERMISSION TO TRANSPORT

I give my permission for the minor, **if applicable**, 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.

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:** Emergency Contact People must be able to transport the expectant applicant in the event of an emergency if the legal guardian cannot be reached. Emergency contacts must be aware they are designated as such.

## EMERGENCY CONTACTS (must include 2 contacts other than applicant and secondary parent)

| FIRST CONTACT NAME | RELATIONSHIP TO APPLICANT |
|---|---|
| PHONE ☐ Home ☐ Cell ☐ Work | ADDRESS |
| SECOND CONTACT NAME | RELATIONSHIP TO APPLICANT |
| PHONE ☐ Home ☐ Cell ☐ Work | AD |

| **PREGNANT APPLICANT SIGNATURE** | PRINT NAME | DATE |
|---|---|---|
| **PARENT/GUARDIAN SIGNATURE** (If applicant is a minor) | PRINT NAME | DATE |