Pregnancy Services for your Family

Apply today!

Now accepting applications for 2026-2027 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

HEAD START & EARLY HEAD START PROGRAMS

UPDATED AUGUST 2026

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

APPLICANT'S RACE/ETHNICITY

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

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

HEAD START & EARLY HEAD START PROGRAMS

UPDATED AUGUST 2026

CHAMPLAIN VALLEY Head Start | CVOEO Champlain Valley Office of Economic Opportunity

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

HEAD START & EARLY HEAD START PROGRAMS

UPDATED AUGUST 2026

CHAMPLAIN VALLEY Head Start | CVOEO Champlain Valley Office of Economic Opportunity

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

HEAD START & EARLY HEAD START PROGRAMS

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CHAMPLAIN VALLEY Head Start | CVOEO Champlain Valley Office of Economic Opportunity

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 or kinship care?	☐ 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 or eligible for Reach Up?	☐ Yes ☐ No
Is your family **currently** receiving or eligible for Supplemental Security Income (SSI)?	☐ Yes ☐ No
Is this applicant **currently** receiving or eligible for 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

HEAD START & EARLY HEAD START PROGRAMS

UPDATED AUGUST 2026

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 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.

I understand that Champlain Valley Head Start is a program of the Champlain Valley Office of Economic Opportunity (CVOEO) and that relevant information about my child or family may be shared with other CVOEO programs on an "as needed basis".

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

HEAD START & EARLY HEAD START PROGRAMS

UPDATED AUGUST 2026

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): _____

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 PROGRAMS

UPDATED AUGUST 2026

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, 2027.

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:_____

PHOTO/VIDEO RELEASE

HEAD START & EARLY HEAD START PROGRAMS

UPDATED AUGUST 2026

USE OF PHOTOGRAPHS/VIDEO

☐ Yes ☐ No EXTERNAL: I give my permission to Champlain Valley Head Start or its funders/partners to use photos and/or video of me and/or my family with the understanding that I and/or my 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.

☐ Yes ☐ No INTERNAL: I give my permission to Champlain Valley Head Start to use photos and/or video of me and/or my family for the purpose of internal program communication such as, but not limited to, family newsletters, TalkPoints messages, and other forms of communication between CVHS and current program participants.

I acknowledge that:

- I may revoke this authorization by contacting CVHS at the following phone number: 802-651-4180 x205
- Any photos and/or videos taken or filmed while this authorization is in effect may be used in in accordance with the selections above in perpetuity.

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:_____

EMERGENCY

HEAD START & EARLY HEAD START PROGRAMS

UPDATED AUGUST 2026

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