New River Community Action, Inc
Floyd Head Start Program
P.O. Box 849.
323Floyd Hwy South
Floyd, VA 24091
540.745.2120

Floyd County Public Schools
Virginia Preschool Initiative
140 Harris Hart Rd NE.
Floyd, VA 24091
540.745.9400

App. #_____

Verification of Birth ( ) Yes ( ) No

Type of Document_____

Document #_____

Floyd County Preschool Application
Virginia Preschool Initiative and NRCA Floyd County Head Start

Child's Information

(first) (middle) (last)

Child's Full Name:_____Date of Birth:_____ ( ) Male ( ) Female

Residence:_____

Mailing Address:_____

Directions to the home. *Please include route numbers and significant landmarks.* _____

_____

Please list current and past preschool/Child Care programs your child has attended: Name of preschool/Child Care: _____

Have you applied to another HS or VPI program for 2017 - 2018? (Yes)__(_No)___

Parent/ Guardian Information

Name:_____Date of Birth:_____ Lives with child: ( ) Yes ( ) No

Employer:_____Total Hours/Week:_____Work #:_____

Cell/Message Phone Number:_____ E-mail Address: _____

Parent/Guardian Information

Name:_____Date of Birth:_____ Lives with child: ( ) Yes ( ) No

Employer:_____Total Hours/Week:_____Work #:_____

Cell/Message Phone Number:_____ E-mail Address: _____

Others in Household-please include all siblings (For Head Start Staff-Related by Blood, Marriage or Adoption)

(Name) (Relationship to Child) (Date of Birth)

_____

_____

_____

Does your child have insurance? Yes ( ) No ( )Please check all types of insurance that apply:

☐Private Medical Insurance ☐ Private Dental Insurance ☐Medicaid

Date of child's last physical:_____ Date of child's last dentist visit:_____

Are your child's immunizations (shots) up to date? ( ) Yes ( ) No

Program Selection

Please consider my child for the following program(s). I understand that there are limited spaces available in all programs. Please list 1st, 2nd, 3rd and 4th choices.

_____ Head Start services (3 & 4 years olds)

_____ Floyd County Public Schools Virginia Preschool Initiative (4 years old = full school day)

_____Head Start Part Day Services (4 Days a Week-Tuesday thru Friday mornings)

_____ Referral to Children's Health Improvement Partnership, Home-Visiting Program (in-home Parent Educator and Nurse visits)

(CHIP serves pregnant mothers and those with at least one child in the home six years old or younger)

Additional Family Information

1. Does your child have any special needs we should be aware of such as:

( ) Developmental Delay ( ) Speech /Language Disorders ( ) ODD, OCD, ADHD
( ) Autism ( ) Traumatic Brain Injury ( ) Visual Impairment
( ) Hearing Impairment ( ) Orthopedic impairment or physical limitations

2. Does your child receive special education services or related services (have an IFSP or IEP) and /or receive treatment from a doctor for any of the above special needs? ( ) Yes ( ) No *(If yes, staff please obtain Release of Information.)*

3. Does your child have any health problems, chronic conditions, or developmental concerns? ( ) Yes ( ) No If marked yes please list and explain: *(May use separate piece of paper)*_____

_____

4. In the past 12 months has the family experienced: domestic violence___ homelessness___ incarceration___ lack of food___ CPS involvement___ Is child a Foster Child (Y or N) drug/alcohol addiction___ Other traumatic event___ No answer__

5. Education/Training: *(Complete only for parent/guardians living with child)*

	Mother /Guardian 1	Father /Guardian 2
No GED/Diploma (Last grade attended)		
Has GED/Diploma		
Some College/Associate's Degree/ Other Training (Please Circle One)		
Has College Degree (Bachelor's or above) **Please List Degree(s)**		

6. Work/School: *(Please put checkmark in all boxes that apply for each)*

	Mother/Guardian 1	Father/Guardian 2
Work 20 hours or less/week		
Work 20-30 hours a week		
Work 30+ hours a week		
School part-time (# of hours) **WHERE?**		
School full-time (# of hours) **WHERE?**		

7. Do you receive housing assistance ? (i.e. rental assistance, no monthly rent or mortgage payment, HUD or other subsidy)? ( ) Yes ( ) No

8. Primary Language in household? _____

9. **Transportation: Not available in all specific locations only. Check with individual centers.**
   Available to transport?( ) Yes ( ) No To a bus stop?( )Yes ( )No
   What prevents you from being able to transport your child? _____

10. **Your total annual family income: _$_____**

(Head Start and VPI will need verification of income from the past 12 months)

New River Community Action Head Start and Floyd County Public Schools program takes into consideration a number of factors in order to determine eligibility. In addition to your income level and the age of your child, other children, and family needs are noted. The information is voluntary. This information will be considered along with other information shared with our staff during the application process in order to determine eligibility and become familiar with your family. By signing the application below, I authorize the release of all medical, dental, educational, and developmental information to be shared by New River Community Action Head Start and Floyd County Public Schools.

_____ _____ _____
Parent /Guardian Signature Staff Signature Date