



Early Head Start Pre-Enrollment Application

What's Early Head Start? (EHS)

Early Head Start (EHS) is an evidence based program that provides low income pregnant women and teen mothers, children from birth to age 3 with family-centered services that facilitate child development, strengthen parental roles and support parents from school to work.

4801 Colonial Drive, Columbia SC 29203
VitalConnectionsMidlands.org
Phone: 803-661-8685

*****Please make sure all information is completed below*****

Today's Date: _____

Child Name: _____

Nombre de niño

DOB/EDD: _____

Fecha de nacimiento

Parent Name: _____

Nombre del padre

Phone#: _____

Número de teléfono

Address: _____

Dirección

Mobile#: _____

Número de teléfono móvil

State: _____ **Zip Code:** _____

Estado

Código postal

County: _____

Condado

Plan to attend (circle one) Tender Years Arthurtown Children's Garden First Available Site

(circule uno) Planifique asistir a la escuela

Referred By: _____

Referido por

Phone#: _____

Número de teléfono

Agency Referred By: _____

Agencia referida por

For Agency Use Only

Para uso exclusivo de la agencia

Staff Signature: _____ **Date:** _____

Date Received at Office: _____ **Signature:** _____

Contact Notes: (Calls, appointment date and time, etc) _____



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Vital Connections of the Midlands Early Head Start AUTHORIZATION FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

Child Name: _____

Child's Date of Birth: _____

Parent's Name: _____

Address: _____

INFORMATION RELEASED/EXCHANGED FROM:

Name: _____

INFORMATION RELEASED/EXCHANGED TO:

Name: _____

Address: _____

Initial Here

☐

Permission is granted to RELEASE TO and RELEASE FROM both parties above if box is initialed by authorizing person.

PURPOSE OR NEED FOR DISCLOSURE:

- [] Evaluation
[] Consultation Regarding Client with Other Community Agency _____
[] Therapy, Continuity of Care
[] Other _____

SPECIFIC INFORMATION TO BE DISCLOSED:

- [] Evaluation
[] Consultation Regarding Client with Other Community Agency _____
[] Therapy, Continuity of Care
[] Other _____

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION:

I hereby authorize the release and/or exchange of the above identifying information from my records. I hereby release _____ from all legal responsibility or liability that may arise from this Authorization. This Authorization may be revoked by me at any time, except to the extent that action has been taken in reliance thereon, by the notification of _____, of my intention to do so. This consent will automatically expire in 90 days, unless some earlier date, event or condition listed below is specified or unless the client (or guardian) specifically revokes such consent with a signed written notice.

SPECIFIC CONDITIONS:

A person served may specify a longer period of time if services are expected to continue beyond 90 days up to 180 days. Length of time if longer than 90 days: _____

Child's Name

Date

Signature of Parent/Guardian

Relationship

Date

Signature of Witness

Date

NOTICE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Par 2, Sec.2.31 of PL-93-282.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. **REVOCATION OF CONSENT:** I revoke the authorization as stated above and as such no further information will be released.

Signature of Person Authorized to Consent

Date and Time