

Skyline CAP Head Start
Enrollment Application Information

PLEASE KEEP THIS COVER SHEET FOR FUTURE REFERENCE.

Head Start is a comprehensive preschool program that primarily serves children from income eligible families. Children must have reached their third or fourth birthday by September 30 of the enrollment year. We welcome children with disabilities. We also take into consideration factors that may put the family at risk. Skyline CAP, Inc. does not discriminate on the basis of race, color, religion, sex, national origin, or handicap.

Our telephone number is **540 948-3916**. We serve families in the counties of Greene (**ext. 210-Fay**), Madison (**ext. 210-Fay**), Warren (**ext. 271-Amanda**), and Page (**ext. 271-Amanda**). Our main office is located in Madison, VA (**540 948-3916 ext. 210-Fay**).

INSTRUCTIONS FOR APPLICATION PROCEDURE – If you need assistance or have questions, call any of the numbers above. Your child cannot be considered for placement until all of the checked items are received.

- ✓ **The attached/enclosed application** completely filled out
- ✓ **Birth certificate** (if born in VA you can get a birth certificate at any VA Health Dept.)
- ✓ **Proof of total household income from all sources** (not needed if foster family, on public assistance, homeless, or anyone in the family is receiving SSI).

If you are receiving public assistance or SSI we need only the following.

- Cash assistance (TANF or SNAP) DSS award letter or copy of signed EBT card front & back
- SSI documents
- If the child is in foster care, we need something from the agency who has custody.
- If you are raising someone else's child (but child NOT in foster care) you need to complete a Kinship care form, available upon request.
- If you have NO income we must have a letter of support from the person(s) supporting your family or a zero-income statement, available upon request.
- If you are homeless (this includes if you had to move in with friends/family) you need to complete a living situation survey, available upon request.

All others:

- Please send COPIES of following documents:
 - W-2s or tax return for the previous year **or**
 - Pay check stubs for the last month **or**
 - Letter from your employer with income information **or**

If the following income applies, we also need verification.

- | | |
|-----------------------|--|
| * SSDI (award letter) | * Child Support (award letter or copy of checks) |
| * Veteran's Benefits | * Social Security |
| * Unemployment | * Worker's Comp |

Upon receipt of all the above needed information you will be notified of your child's status in the program. This could take up to 30 days and unfortunately sometimes longer. **Submitting this application does not mean that the child is enrolled.**

If your child is chosen for the program required documents would include a signed up-to-date immunization record, current physical (within the last year) and a dental exam (within the last six months).

If your address or telephone number changes while waiting to hear from us please call us with the changes. Please return your application to our Administration office: **Skyline CAP Head Start, 532 S Main Street, Madison VA 22727** or your local family advocate. Our fax number is **540 948-2264** or email familymanager@skylinecap.org – Fay.

Please list everyone in the house (include parents and children) – Por favor apunte todos los miembros en casa (incluya padres e hijos)

Name – Nombre	Birthdate - Fecha de Nacimiento	F/M	Where do you work? ¿Dónde trabaja?	Employer tel # Número de teléfono de empleador	Highest level of Education último grado escolar

Family Characteristics - Características de familia

We have limited space; placement is offered based on highest needs. Tenemos espacio limitado y colocación se ofrece de acuerdo con los más necesitados.

(Check all that apply) La familia recibe TANF, etc.- (marque lo que aplica) Receiving benefits:

☐ **TANF** ☐ **Medicaid** ☐ **FAMIS** ☐ **Food Stamps** ☐ **SSI**
☐ **WIC** ☐ **child support,** ☐ **unemployment** ☐ **rental assist**

☐ **Significant behavior** ☐ **ADHD** ☐ **special dietary needs,**
☐ **on prescription medications** Conducta o el discurso
significativos conciernen, el peso bajo del nacimiento, o las necesidades
nutricionales on prescripción medicación

☐ **Single parent,** ☐ **incarcerated parent, or** ☐ **parent
loss by death—Padre soltero, encarcelado o fallecido**

☐ **Outside agency referral, who?— Referencias de alguna
agencia de afuera, ¿Quien?**

☐ **Child** ☐ **is** ☐ **was in foster care – El niño está/ha
estado con personas adoptivas**

☐ **Medical insurance lacking for household member E/
seguro médico que carece para el miembro de la casa**

☐ **Prior or current CPS (Child Protective Service) involved
(Servicios de Protección Infantil) que participan** ☐

☐ **Current debt or inability to pay monthly bills even
when benefits are applied La deuda o la incapacidad actuales pagar
cuentas mensuales**

☐ **Child has been abused (sexually, physically, or
emotionally), - El niño ha sido abusado (sexualmente, físicamente
o emocionalmente)**

☐ **Both parents unemployed—Dos padres desempleados**

☐ **Substance abuse** ☐ **Substance addiction**

☐ **English language learner Inglés como segunda lengua**

☐ **Domestic violence (parent to parent, parent to
child, child to child)— Violencia doméstica**

☐ **Parent unable to read/write Críe lectura/escritura incapaz**

☐ **Unstable housing alojamiento inestable**

☐ **Prior or current Head Start** ☐ **VPI** ☐ **Special
Education family member** ☐ **Healthy Families – Un
hermano/a del niño ha participado en el programa anteriormente**

☐ **Overcrowded housing alojamiento superpoblado**

☐ **Moved in with friends/relatives vive con amigos/familiares**

☐ **Recent immigrant/refugee-From**

Inmigrante o refugiado recién – De:

☐ **Moved 2 or more times in the last six months –
Movi6 2 o más tiempos en los últimos seis meses**

☐ **seasonal Migrant worker trabajador migrante estacional**

☐ **Chronically ill family member (physical, mental, emotional,
substance abuse/addiction) Who? What? Alguna persona
cr6nicamente enferma en la familia (física, mental, emocional, abuso de
sustancias/adiciones) ¿Quién? ¿Qué? _____**

**Is your child completely potty trained? (This is NOT
a requirement for Head Start) ¿Su hijo usa el baño
solo completamente? (Esto NO es un requisito de Head
Start)** ☐ **Yes -** ☐ **Sí** ☐ **No -** ☐ **No**

☐ **Active Military Militar Activo** ☐ **Veteran Veterana**

☐ **Other – Otro**

Mail, FAX 540 948-2264 or email this application to: familymanager@skylinecap.org (Telephone # 540 948-3916 x210)

I understand this is an application ONLY and does not guarantee enrollment in the program. I also understand that I MUST keep Head Start informed of any changes of address or phone number. I declare that I have given complete, accurate, and truthful information and certify that the documents and information that I've provided concerning eligibility are accurate to the best of my knowledge. Entiendo que esta es SOLAMENTE una aplicación y no garantiza matriculación en el programa. También entiendo que NECESITO informar a Head Start si hay algún cambio de dirección o de número de teléfono. Declaro que he dado información completa, exacta y veraz y certifique que los documentos y la información que he proporcionado acerca de la elegibilidad son exactos al mejor de mi conocimiento.

☐ **If you check this block you DO NOT want information shared with other preschool programs. Marque no información a otro pre-escolar.**

Where did you obtain this application? ¿Cómo obtuvo usted esta aplicación? _____

Signature – Firma

Date – Fecha