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. 273 - Tireza), Madison (ext. 272-Sandy), 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 compete 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 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 Butcher.**

Policy Council approved: 10/24/2025/ApplicationCoverLetter

SKYLINE CAP HEAD START – 532 S Main Street, MADISON, VA 22727

APPLICATION – APLICACION

Skyline CAP, Inc. does not discriminate on the basis of race, color, religion, sex, national origin, or handicap.

Skyline CAP, Inc. no discrimina a base de raza, color, religión, sexo, origen nacional, o incapacidades.

Full Name of child – *Nombre del Niño* **Male** – *Niño* **Female**- *Niña* **(Please provide birth certificate**-*Necesitamos la acta de nacimiento)*	**Birth date**–*Fecha de Nacimiento* **Birthplace**: *Lugar de Nacimiento* **Race**-*Raza:*	**Hispanic:**□ **yes** □ **No** Hispanos: □ Si □ No	**Household Income (gross)** – *Ingresos* *$ _____/month or* *$_____/year* **(Please provide proof of income** - *Por favor proveer prueba de ingresos)*

Mother/legal guardian name -*Nombre de la madre o guardián legal* Birthdate:	**Father/legal guardian name**–*Nombre del padre o guardián legal* Birthdate:

Relationship to child – Relación al Niño □ **Parents** – *Padres* □**Grandparents** – *Abuelos* □ **Foster parent** – *Padres de Crianza*
□ **Other relative** – *Otros parientes* □ **Person having legal custody/guardianship** – *Persona que tiene custodia legal*

Living Status: □ **I own my home** □ **I rent** □ **Rental Assistance** □ **live with friends/relatives** □ **homeless** □ **Shelter**
Estado de vida:*□*Soy dueño de mi casa* □*Rento* □ *Asistencia de alquiler* □*Vivo con amigos/parientes* □*Sin hogar* □*Refugio

Mailing Address-*Dirección de Correo* **City, State, Zip**-Ciudad, *Estado y Código* Postal :	**Street Address**-*Dirección Actual* **City, State, Zip** -*Ciudad, Estado y Código Postal*
Mother's address if different: La dirección de la madre si diferente:	**Father's address if different:** La dirección del padre si diferente:

Email address *Dirección de correo electrónico*

Mom/Madre *Dad/Padre*

How many years have you lived in this County? *¿Cuántos años ha vivido usted en este Condado?*

Cell #s ***Celda #s*** **Mom:** **Dad:** **Home Phone #** - *Número de teléfono en casa*	**If no phone -Message phone, name & #** - Si no hay teléfono - *Número de teléfono para recados, y nombre*	**Does child have any allergies?-** *¿Tiene su hijo/a alergias?* **If so, explain:** - Si asi, *explique*:
Primary language spoken in the home–*Idioma principal que se habla en casa*	**What language does the child speak at home?** *¿Qué idioma habla su hijo/a en casa?*	**How well does the child speak English?-** *¿Cómo habla su hijo/a el inglés?* □ **Well-** *Bien* □ **Not well-***No muy bien* □ **none-** *Nada*

Name and telephone number of interpreter if needed: *Nombre y número de teléfono del intérprete si es necesario*

Please indicate any of the following services your child is receiving – *Por favor indique los servicios que su niño/a está recibiendo.* **Does your child have an IEP?** *¿Tiene su hijo un IEP?* □ **Yes** - □ *Sí* □ **No** - □*No*
□**Occupational Therapy/Physical Therapy**–*Terapia Ocupacional/Terapia Física*
□**Speech/Language** – *Habla/Idioma* □**Hearing** – *Oír* □**Vision** – *Vista*
□**Developmental** – *Desarrollo* □**Other** – *Otro* **(Specify** - Especifique): _____

Do you have any concerns about your child's development or speech/language? *¿Tiene alguna preocupación sobre el desarrollo de su hijo/a. Habla/Idioma?* □ **Yes** - □ Sí □ **No** - □*No* **Please describe your concern if you have one (*add a page, if needed*):** Si es así explique, por favor (Agregue una página, si necesario):

Do you have transportation available to get your child to and from the classroom? (Transportation not guaranteed)
¿Tiene usted transporte disponible para llevar a su niño/a a la escuela? (El transporte no es garantizo) □ **Yes** - □ *Sí* □ **No** - □*No*

What is your child's medical insurance? *¿Qué seguro médico tiene su hijo/a?* _____

What is the insurance number? *¿Cual es el número del seguro medico?*_____

Doctor's Name _____ **Dentist Name**_____

EMERGENCY CONTACTS Name, address, tel #(other than parents)–*CONTACTOS DE EMERGENCIA Nombre y dirección telefono (no padres)*

1. _____
2.

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** *El 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* □ **Parent unable to read/write** *Críe lectura/escritura incapaz*	□ **Domestic violence (parent to parent, parent to child, child to child)**– *Violencia doméstica*
□ **Unstable housing** alojamiento inestable □ **Overcrowded housing** alojamiento superpoblado □ **Moved in with friends/relatives** vive con amigos/familiares	□ **Prior or current Head Start** □ **VPI** □ **Special Education family member** □ **Healthy Families** – *Un hermano/a del niño ha participado en el programa anteriormente*
□ **Recent immigrant/refugee-From** *Inmigrante o refugiado recién – De:* □ **seasonal Migrant worker** *trabajador migrante estacional*	□ **Moved 2 or more times in the last six months** – Movió 2 o más tiempos en los últimos seis meses
□ **Chronically ill family member (physical, mental, emotional, substance abuse/addiction) Who? What?** *Alguna persona crónicamente 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 qarantiza matriculacion 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