

Skyline CAP Head Start Enrollment Application Information

PLEASE KEEP THIS COVER SHEET FOR FUTURE REFERENCE.

Head Start is a **free** need based 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 disability.

Our telephone number is **540 948-3916**. We serve families in the counties of Greene (**ext. 273** - Tirez), 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. Eligibility will be determined after all of the required documents 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.)
- ✓ **One of the following documents:**
 - **If you are receiving public assistance or SSI we need only the following.**
 - If you are on TANF or SNAP we need the DSS award letter or copy of signed EBT card front
 - If you are on SSI we need the document stating you are receiving SSI
 - **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 is 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 need to supply proof of total household income for the Head Start family:

- 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.

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

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Skyline CAP, Inc. no discrimina por raza, color, religión, sexo, nacionalidad, 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		Household Income (gross) – Ingresos antes de impuestos \$ _____/month or \$ _____/year (Please provide proof of income - Por favor proveer prueba de ingresos netos)
		Birthplace: Lugar de Nacimiento		
		Race-Raza:	Hispanic: <input type="checkbox"/> yes <input type="checkbox"/> No Hispano: <input type="checkbox"/> Si <input type="checkbox"/> No	
Mother/legal guardian name -Nombre de la madre o guardian legal Birthdate: _____		Father/legal guardian name–Nombre del padre o guardian legal Birthdate: _____		
Relationship to child – Relación con el menor <input type="checkbox"/> Parents – Padres <input type="checkbox"/> Grandparents – Abuelos <input type="checkbox"/> Foster parent – Padres de Cuidado <input type="checkbox"/> Other relative – Otros parientes <input type="checkbox"/> Person having legal custody/guardianship – Persona que tiene custodia legal del menor				
Living Status: <input type="checkbox"/> I own my home <input type="checkbox"/> I rent <input type="checkbox"/> Rental Assistance <input type="checkbox"/> live with friends/relatives <input type="checkbox"/> homeless <input type="checkbox"/> Shelter Estado de vivienda: <input type="checkbox"/> Soy dueño de mi casa <input type="checkbox"/> Rento <input type="checkbox"/> Asistencia de alquiler <input type="checkbox"/> Vivo con amigos/parientes <input type="checkbox"/> Sin hogar <input type="checkbox"/> 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 es diferente: _____		Father’s address if different: La dirección del padre si es diferente: _____		
Email address Dirección de correo electrónico <i>Mom/Madre</i> _____ <i>Dad/Padre</i> _____				
How many years have you lived in this County? ¿Cuántos años ha vivido usted en este Condado? _____				
Cell # Celular # Mom: _____ Dad: _____ Home Phone # - Número de teléfono de 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, 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? <input type="checkbox"/> Well-Bien <input type="checkbox"/> Not well-No muy bien <input type="checkbox"/> none-Nada
Name and telephone number of interpreter if needed: Nombre y número de teléfono del intérprete si se requiere _____				
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? <input type="checkbox"/> Yes - <input type="checkbox"/> Sí <input type="checkbox"/> No - <input type="checkbox"/> No <input type="checkbox"/> Occupational Therapy/Physical Therapy–Terapia Ocupacional/Terapia Física <input type="checkbox"/> Speech/Language – Habla/Idioma <input type="checkbox"/> Hearing – Oír <input type="checkbox"/> Vision – Vista <input type="checkbox"/> Developmental – Desarrollo <input type="checkbox"/> Other – Otro (Specify - Especifique): _____				
Do you have any concerns about your child’s development, speech/language or medical concerns? ¿Tiene alguna preocupación sobre el desarrollo de su hijo, su habla/lenguaje o algún problema médico? <input type="checkbox"/> Yes - <input type="checkbox"/> Sí <input type="checkbox"/> No - <input type="checkbox"/> No Please describe your concern if you have one (add page, if needed): Si es así explique, por favor (Anexe una hoja): _____				
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? (No se provee transporte) <input type="checkbox"/> Yes - <input type="checkbox"/> Sí <input type="checkbox"/> No - <input type="checkbox"/> No				
What is your child’s medical insurance? ¿Qué seguro médico tiene su hijo/a? _____				
What is the insurance number? ¿Cuál es el número del seguro médico? _____				
Doctor’s Name _____		Dentist Name _____		
EMERGENCY CONTACTS Name, relationship, address, tel #(other than parents)– CONTACTOS DE EMERGENCIA Nombre, parentesco, dirección, número de teléfono (distinto al de los padres) 1. _____ 2. _____				

Please list everyone in the house (include parents and children)-Por favor enliste todos los miembros que viven en casa (incluya padres e hijos)

Name and relationship – Nombre y parentesco	Birthdate - Fecha de Nacimiento	F/M	Where do you work? ¿Dónde trabaja?	Employer tel # Número de teléfono del 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 la seleccion se ofrece de acuerdo con los más necesitados.

(Check all that apply) La familia recibe TANF, etc.- (marque lo que aplica) Receiving benefits: <input type="checkbox"/> TANF <input type="checkbox"/> Medicaid <input type="checkbox"/> FAMIS <input type="checkbox"/> SNAP <input type="checkbox"/> SSI <input type="checkbox"/> WIC <input type="checkbox"/> child support, <input type="checkbox"/> unemployment	<input type="checkbox"/> Significant behavior <input type="checkbox"/> ADHD <input type="checkbox"/> special dietary needs, <input type="checkbox"/> on prescription medications Conducta del comportamiento, el peso bajo en el nacimiento, o las necesidades nutricionales y medicamentos con receta
	<input type="checkbox"/> Single parent, <input type="checkbox"/> incarcerated parent, or <input type="checkbox"/> parent loss by death—Padre soltero, encarcelado o fallecido
<input type="checkbox"/> Outside agency referral, who?— Referencias de alguna agencia de afuera, ¿Quién?	<input type="checkbox"/> Child <input type="checkbox"/> is <input type="checkbox"/> was in foster care – El niño está o ha estado con personas de cuidado
<input type="checkbox"/> Medical insurance lacking for household member El seguro médico que carece para el miembro de la casa	<input type="checkbox"/> Prior or current CPS (Child Protective Service) involved (Servicios de Protección Infantil) que participan <input type="checkbox"/>
<input type="checkbox"/> Current debt or inability to pay monthly bills even when benefits are applied La deuda o la incapacidad actuales pagar cuentas mensuales	<input type="checkbox"/> Child has been abused (sexually, physically, or emotionally), - El niño ha sido abusado (sexualmente, físicamente o emocionalmente)
<input type="checkbox"/> Both parents unemployed—Dos padres desempleados	<input type="checkbox"/> Substance abuse <input type="checkbox"/> Substance addiction
<input type="checkbox"/> English language learner Inglés como segunda lengua	<input type="checkbox"/> Domestic violence (parent to parent, parent to child, child to child)— Violencia doméstica
<input type="checkbox"/> Parent unable to read/write Padres analfabetos(sin escolaridad)	<input type="checkbox"/> Prior or current Head Start <input type="checkbox"/> VPI <input type="checkbox"/> Special Education family member <input type="checkbox"/> Healthy Families – Un hermano/a del niño ha participado en el programa anteriormente
<input type="checkbox"/> Unstable housing vivienda inestable <input type="checkbox"/> Overcrowded housing vivienda sobrepoblada <input type="checkbox"/> Moved in with friends/relatives vive con amigos o familiares	<input type="checkbox"/> Moved 2 or more times in the last six months – Se a movido 2 o más veces en los últimos seis meses
<input type="checkbox"/> Recent immigrant/refugee-From Inmigrante o refugiado reciente – De que país: <input type="checkbox"/> seasonal Migrant worker trabajador migrante temporal	<input type="checkbox"/> 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) <input type="checkbox"/> Yes - <input type="checkbox"/> Sí <input type="checkbox"/> No - <input type="checkbox"/> No
<input type="checkbox"/> 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/adicciones) ¿Quién? ¿ Cual? _____	<input type="checkbox"/> Other – Otro
<input type="checkbox"/> Active Military Militar Activo <input type="checkbox"/> Veteran Veterano	(This section is merged into the previous row in the original image)

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 la inscripción 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 certifico que los documentos y la información que he proporcionado tienen elegibilidad son exactos al mejor de mi conocimiento.

If you check this block you DO NOT want information shared with other preschool programs. Si marca el cuadro significa que NO autoriza que su información sea compartida con otras instituciones para preescolares.

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

Signature – Firma _____

Date – Fecha _____