

Pittsylvania County Community Action, Inc. Head Start Program

**(Pre-School)
HEAD START PROGRAM APPLICATION
2021-2022**

CHILD'S NAME: _____ AGE: _____
DOB ___/___/___

PARENT'S NAME: _____ AGE: _____ DOB ___/___/___

Do you work, attend school, or are enrolled in a job training program full time? ___ Yes ___ No

If yes, please specify: _____

To be considered for enrollment for the 2021-22 school year, all pages must be filled out in their entirety. The first four (4) documents **are required:**

- 1. Income verification documents (2020 W'2, 1040 Tax Form, Check Stub, TANF or SSI, Other)**
- 2. Verification of your child's age (Birth Certificate or Hospital Record with signature and seal)**
- 3. Custody Papers (if applicable)**
- 4. Up-to-date Immunization Record**
- 5. Physical (current with blood lead & blood count) and current Dental Record**

If you have any questions about the Head Start Program, please call one of the following sites:

1. Martinsville City
 - Refuge Temple Center (1A & B) (276) 252-2007 or (434) 432-8911
 - Refuge Temple Center (2)
2. Henry County
 - Moral Hill Center (276) 252-2007 or (434)432-8911
 - Stanleytown Center (276) 252-2007 or (434)432-8911
3. Campbell County (Altavista Center) (434) 432-8911 or (276) 252-2007
4. Pittsylvania County
 - Chatham (Joseph Galloway Center) (434) 432-8911 or (276) 252-2007
 - Shiloh Center (434) 432-8911 or (276) 252-2007
 - Bethel Center (434) 432-8911 or (276) 252-2007

*****We Gladly Accept Children With Special Needs*****

Head Start does not discriminate against children or families based upon race, color, national origin, or special needs.



PITTSYLVANIA COUNTY COMMUNITY ACTION INC.
 HEAD START – PRE-SCHOOL; A PATH TO SCHOOL READINESS

P.O. BOX 1119, CHATHAM VA 24531

2021-2022

CHILD ENROLLMENT APPLICATION

Center # _____ New Enrollee Returnee Waiting Pending

Name of Child _____ Birth Date _____ Birth Certificate # _____

Gender: Male Female Ethnicity: B W Other Hispanic Bi-Racial

Head of Household: Mother / Father (circle one)

Mailing Address if different from Living Address: _____

Email Address: _____

Verified by staff: _____
 Title: _____

Marital Status: Single Married Divorced Separated Widowed Two Parent Household

Mother/Guardian (circle one) Name: _____

Date of Birth: _____ Ethnicity: B W Hispanic Bi-Racial Other

Living Address: _____ City _____ State _____
 Zip _____

Email Address: _____

Telephone Numbers: (Home) _____ (Cell) _____ (Contact #) _____

Employer: _____ Work Hrs. _____ Business Telephone Number: _____

Unemployed as of: _____ Disabled yes no

*Please specify if you are currently enrolled in school or a job training program

Father/Guardian (circle one) Name: _____

Email Address: _____

Date of Birth: _____ Ethnicity: B W Hispanic Bi-Racial Other

Living Address: _____ City _____ State
_____ Zip _____

Telephone Numbers: (Home) _____ (Cell) _____ (Contact #)

Employer: _____ Business Telephone Number:

Unemployed as of: _____ Disabled yes no

*Please specify if you are currently enrolled in school or a job training program

Magisterial Jurisdiction: Martinsville City Henry County Pittsylvania County
Campbell County

Directions from the child's home to school:

Do you have transportation to get your child to and from the classroom? YES NO

Does the child have any allergies? yes no

If yes, please explain

What is the primary language spoken at home? _____ What language does the child speak at
home? _____

Family uses English as a second language yes no

How well does the child speak English? Well Not Well Not at all

Does your child have Medical Coverage? YES NO Does it cover Dental Services? YES NO If yes, please
give the name of the

Dentist _____

Does the child have Medicaid? YES NO Does the child have Private Insurance? YES NO If
yes, please indicate

• FAMIS YES NO

The name of the Private Insurance _____

• Name of Medical Doctor _____

Do either/both of the parents have health insurance? YES NO If yes, what type?

Does your child attend any pre-school classes? YES NO If yes, what pre-school?

Does your child have a disability Yes No If yes, what type? _____

Do you have any concerns about your child's development in any of the following areas?

Physical Development Vision Speech Hearing Behavior Other

Please check any box to indicate which of the following services your child is receiving:

Speech Pre-school Occupational Therapy / Physical Therapy Developmental

Hearing Language Vision Other Explain: _____

FAMILY FACTORS: Please check all that apply to the child's family:

Family homeless without a roof yes no
risk pregnancy

Child was born prematurely/high

yes no

Did you graduate high school? yes no
yes no

*Family receives Food Stamps

Do you have a GED? yes no
no

Child receiving WIC yes

Child in a foster home Yes No

Social Services is involved in the family yes no
yes no

Child received WIC in the past

Parent deployed /military yes no
yes no

Teen Parent at child's birth

Deceased Parent yes no

Child or family is in counseling yes no
 no

Parent has a mental illness yes

Parent or Guardian is incarcerated if so, who? _____
 yes no

Substance abuse in the household

Chronic or terminal illnesses in family yes no
yes no

Domestic violence in the home

Child has a chronic illness yes no

Child has health insurance yes no

*Child/family member receiving SSI yes no

*Receiving Pension yes no

*Receiving TANF yes no

*Child receiving child support yes no

***Required: If Receiving** _____

Please list number in immediate family living in the home **whose income support the Household.**

Parent/Legal Guardian Names	Birth Date	Relationship to Child	Race	Highest Level of Education

To include Head Start Child:

Children's Name	Birth Date	Sex	Relationship to Head Start Child	Highest level of Education
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PLEASE READ AND SIGN

*****Proof of income is required. Please attach the following to this application: W-2, Paycheck Stub, Income Tax Return (Gross) Income Page Only, (Zero Income Must Provide Notarized Written Statement or Notice of Action Form) Child Support, TANF, Pension, Homeless, Foster Care, SSI, SSA or any other source of income and a copy of your child's Birth Certificate.*****

Parent/Legal Guardian Statement:

I certify that this information is true. I understand that this information will be used to determine whether my child is eligible for Head Start services, but does not guarantee acceptance into the program. I understand that any information that is untrue can result in legal action by the Federal Office of the Administration for Children and Families.

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.

Parent/Legal Guardian Signature:

_____ **Date** _____

If you check this block you DO NOT want information shared with other preschool programs.

Program Use Only:

Number in household _____

Yearly income received yes

Birth date verified yes

Residency verified yes

Staff Statement: I certify that the above information is an accurate depiction of the information given to me by the above signed parent/guardian. No information has been altered or omitted. I understand that actions may be taken which may affect my employment with the PCCA Head Start program for knowingly submitting false information.

Signature of verifying staff member (income): _____
Date _____

Verified by: PFCE Manager _____
Date _____

“This Institution is an Equal Opportunity provider and employer.”