



**Please return/mail the completed application to:**  
 Nicholas County Community Action -Head Start  
**Attn: Christy Skaggs**  
 1205 Broad Street  
 Summersville, WV 26651  
 Phone: 304-872-1162 ext. 1119  
 Fax: 304-883-2036  
 Email: cskaggs@ncapwv.org

## **Nicholas County Early Learning Collaborative**

### **Preschool Application 2024-25**

Child's Name: \_\_\_\_\_ Center Preference: 1.) \_\_\_\_\_  
First, Middle, Last

Child's date of birth: \_\_\_\_\_ 2.) \_\_\_\_\_

3.) \_\_\_\_\_  
(See Pg. 2 for list of available sites)

**Items needed for a complete application include the following:**

- Proof of Income
- Copy of Insurance or Medical Card
- Copy of State Certified Birth Certificate
- Copy of Social Security Card
- Shot Record
- Proof of Physical Address   
(copy of utility bill, copy of personal tax receipt, each showing physical address)
- Physical Form
- Dental Examination Form

**\*Any application that is submitted as incomplete will delay your child's placement into a Nicholas County Early Learning Center classroom. All documents must be submitted at the time of the application.**

**I understand that completion of this application DOES NOT guarantee this child's placement in WV Pre-K, or in your placement of choice. To the best of my ability and knowledge the information on this application is correct. I understand that it is my responsibility to report any changes to this information immediately. If documents are found to be altered or falsified to deceive, this will result in your child being placed on the wait list.**

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Location of Application: \_\_\_\_\_

**Nicholas County Early Learning Eligibility Application 2024-25**

Will before and/or after school childcare be required? (Not available at all sites)  Yes  No

If transportation is not available, can you provide transportation to and from site?  Yes  No

**Sites available:**

Birch River  Mt. Lookout   
Cherry River  Panther Creek  Friends-R-Fun (Child Care available)   
Gauley River  Summersville

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
First, Middle, Last

**Gender:**  Male  Female **Child's Social Security #:** \_\_\_\_\_

**Child's Primary Language:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
Address City State Zip

**Physical Address:** \_\_\_\_\_  
Address City State Zip

**Mother's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Mother's Date of Birth:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Father's Date of Birth:** \_\_\_\_\_

**Guardian's Name (if applicable):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Guardian's Date of Birth:** \_\_\_\_\_

**Parent/Guardian Email:** \_\_\_\_\_

**Guardian's Relationship to Child:**  Foster Parent  Grandparent  Other (documentation required)

If other, please explain: \_\_\_\_\_

**Alternate Contact (please list two):** \_\_\_\_\_  
Name Phone Number Relationship to child

\_\_\_\_\_  
Name Phone Number Relationship to child

## Nicholas County Early Learning Eligibility Application 2024-25

What educational history has your child had?

Head Start \_\_\_\_\_ Birth to Three \_\_\_\_\_  
                            Dates                  Location                                  Dates                  Location

Child Care: \_\_\_\_\_ Circle One: Friends-R- Fun    Starting Points    Toddler Town  
                            Dates

Pre-School: \_\_\_\_\_ Other: \_\_\_\_\_ None:   
                            Dates                  Location                  Dates                  Location

Does your child have an IFSP or IEP?     Yes                   No                   Not Sure

Does this child have any special needs or require any special accommodations?     Yes                   No

Special Needs:     Speech                   Medical/Physical                   Visual                   Hearing                   Other

Has a referral been made for any of the above?     Yes                   No                   Not Sure

### Income Eligibility Information

**Confidentiality Statement:** This information is being requested on a voluntary basis. Some information is required. All information disclosed will be used only on a need-to-know basis by those employees working for the program.

Total Gross Annual Income: \_\_\_\_\_

Income Verification Must Accompany Application.

Source of Income:                   Employment                   TANF                   Unemployment  
   SSI                   SSDI                   Child Support                   SNAP                   No Income

Number of People Living in the Home: \_\_\_\_\_

Name and Date of Birth for all siblings living in the home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Living Arrangements/Housing:

Is your current living arrangement temporary? \_\_\_\_\_

Is this temporary arrangement due to loss of housing or economic hardship? \_\_\_\_\_

Living arrangement:

\_\_\_\_\_ rent/own    \_\_\_\_\_ motel/hotel    \_\_\_\_\_ shelter    \_\_\_\_\_ moving from place to place

\_\_\_\_\_ doubled up    \_\_\_\_\_ car/park/campsite

\_\_\_\_\_ other (explain) \_\_\_\_\_  
\_\_\_\_\_

Name of Parent(s) that the child resides with primarily: \_\_\_\_\_

I understand that the information collected on this application may be shared with one or more of the following early learning/child care providers: Friends-R-Fun, Nicholas County Board of Education, and NCAP, Inc. Head Start. All information obtained will be accessible to only employees who provide services to my child. My signature indicates my understanding of this statement.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

**MEDICAL HISTORY 2024-25**

Child Name: \_\_\_\_\_ Information completed by: \_\_\_\_\_

Does your child have any of the following? Check all that apply.

- ADHD, ADD, or other behavioral problems \_\_\_\_\_
- Anxiety \_\_\_\_\_
- Assistive Devices/Orthotics \_\_\_\_\_
- Asthma \_\_\_\_\_
- Seizures \_\_\_\_\_
- Depression \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Food allergies \_\_\_\_\_
- Medication allergies \_\_\_\_\_
- Other allergies \_\_\_\_\_
- Stomach or bowel problems \_\_\_\_\_
- Physical impairments such as Cerebral palsy, Muscular Dystrophy, or Spina Bifida, etc. \_\_\_\_\_
- Heart Problems/ Defect \_\_\_\_\_
- Kidney or Bladder problems \_\_\_\_\_
- Hearing, Vision, or Speech problems \_\_\_\_\_
- Other health problems \_\_\_\_\_

Medications currently taking: \_\_\_\_\_  
\_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Serious accidents: \_\_\_\_\_

Mental Health concerns: \_\_\_\_\_

Childs Physician: \_\_\_\_\_

Childs Dentist: \_\_\_\_\_

**\*\*\*\*\*School Health Use Only\*\*\*\*\***

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_