



Opportunity
House



pennsylvania
PRE-K COUNTS

Dear Parents/Guardian:

Thank you for your interest in the Pre-K Counts Program offered by Second Street Learning Center/Opportunity House. Please complete the application to determine your child's eligibility. Once this is done, the following documentation will be needed to complete the enrollment process:

- Completed 2026-27 Application
- Copies of your 2025 W-2 form(s) and/or 2025 tax return and other income such as child support, SSI cash assistance, paycheck stubs, etc.
- Copy of your child's birth certificate
- Copy of your child's immunization record
- Attached physical form-must be signed by your child's doctor (within 1 year)
- Copy of your child's IEP/Behavior Plan (if applicable)
- Proof of child's medical insurance

If you are applying for a three-year-old, you must be 3 years old by August 31, 2026, to be eligible. We use a point system that is calculated from the risk factors within the application; we consider children with a higher risk factor score first. This means that if there is minimal space available we will enroll the child with the highest risk factor score first. If the program is full, we maintain a wait list for unexpected vacancies, so registrations are accepted throughout the year. Our planned start date is August 24, 2026.

You can mail the forms or drop them off at the location listed below. Your application will not be considered complete until we have received all required documents and we have verified your income.

Opportunity House/Second Street Learning Center
Attn: Crystal Rowles
430 N. Second Street
Reading, PA 19601

If you have questions, please contact Crystal Rowles at 610-374-4696 ext. 250 or by email at crowles@opphouse.org.

Sincerely

Crystal Rowles, M. Ed.
Assistant Director/Educational Specialist

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME: 2nd St. Learning Center		WORK PHONE:
FACILITY PHONE: 610-374-4096	COUNTY: Berks	
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION
This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.
	VISION (subjective until age 3)
	HEARING (subjective until age 4)
	LEAD

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/ID						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER:
	DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

2026-27 PA Pre-K Counts Enrollment Form

(This information is confidential to the PA Pre-K Counts program)

Date Form Completed:		/		/		Child's SSN		-				
	MM		DD		YY	Last 5 digits	#	-	#	#	#	#

Legal Last Name (Child)	Legal First Name (Child)	Middle Initial
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Street Address	County	
City	State PA	Zip Code
School District of Residence		
Home Phone	Work Phone	Email Address

Child's Date of Birth	Age at start of program year <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Race (optional)	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaskan Native
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> Not Applicable	
Ethnicity (optional)	Primary Language
<input type="checkbox"/> Hispanic	<input type="checkbox"/> English
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Spanish
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Other _____
	(please specify)

Name of Parent or Guardian completing this application	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Relationship to Child	(Select)
<input type="checkbox"/> Father	<input type="checkbox"/> Biological
<input type="checkbox"/> Mother	<input type="checkbox"/> Foster
<input type="checkbox"/> Guardian	<input type="checkbox"/> Adoptive
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
(please specify)	(please specify)

Role	
<input type="checkbox"/> Primary Guardian	<input type="checkbox"/> Legal Guardian
<input type="checkbox"/> Secondary Guardian	<input type="checkbox"/> Other _____
	(please specify)

List Household Members below for determination of family size (required):

	Relationship to Child	Age
1	ENROLLING CHILD	
2		
3		
4		
5		
6		
7		
8		

Per PKC Statute, Regulations, and Guidance, the following members of the household are included in family size:

- Parent of the child (biological or adoptive mother or father, stepmother or stepfather, caretaker or spouse)
- A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
- A child who is 18 years of age or older but under 22 years of age who is enrolled in high school, a general educational development program, or a post-secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent on the income of the parent or caretaker or spouse of the parent or caretaker.
- Others supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program. ***If counted toward family size, any applicable income of these persons must also be counted for eligibility purposes.***

Note: A family size value of one (1) with an income of \$0 is entered when a foster child is applying for Pennsylvania Pre-K Counts.

DETERMINED FAMILY SIZE =

Employment Status of parent/guardian	Employment Status of 2 nd parent/guardian (if applicable)
<input type="checkbox"/> Employed Full-Time	<input type="checkbox"/> Employed Full-Time
<input type="checkbox"/> Employed Part-Time	<input type="checkbox"/> Employed Part-Time
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Household Income Sources (Must check all that apply):				
<input type="checkbox"/> Employment	<input type="checkbox"/> Self-Employment	<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> TANF Cash payments
<input type="checkbox"/> Social Security	<input type="checkbox"/> SSI	<input type="checkbox"/> Child Support	<input type="checkbox"/> Alimony	<input type="checkbox"/> Other

Family Assurances

By signing below, I acknowledge and agree to the following:

- I understand that my child's eligibility for Pennsylvania Pre-K Counts (PA PKC) is subject to the program's two-year participation limit. My child must be at least three years old by the kindergarten cutoff date set by the school district where we live to assure compliance with receiving only two-years of PKC programming.
- Once my child reaches the age required to enroll in kindergarten in the public school district where we live, I understand they will no longer be eligible for PA PKC funding.
- I understand that my child's enrollment is contingent upon meeting the eligibility criteria, including income verification and prioritization based on risk factors.
- I understand that the PA Pre-K Counts (PKC) program is an educational program with attendance requirements. I agree to ensure my child's regular attendance and to notify the program in case of absences. My program's PA Pre-K Counts hours of operation are:

PKC#3 8:45-2:15 / PKC#1 and PKC#2 9:00-2:30

- I understand that the PKC portion of the day will be secular (non-religious) in nature and will not include religious instruction during the PKC portion of the day. My program's PA Pre-K Counts hours of operation are:

PKC#3 8:45-2:15 / PKC#1 and PKC#2 9:00-2:30

- I understand that once an enrollment start date is confirmed, the child's PA Pre-K Counts enrollment status may be shared with other OCDEL-funded programs, such as the Early Learning Resource Center (ELRC) or Early Intervention, to ensure proper coordination of funding and services.

Parent/Guardian Certification

To the best of my knowledge, the information provided in this application and the associated income documentation is accurate. I understand that I may be asked to verify or give proof of information provided.

I certify that all information provided is accurate. I understand that eligibility is subject to verification and providing false information may result in disqualification.

Parent/Legal Guardian (Signature)

Date

Parent/Legal Guardian Name (Print Name)

Family and Program Administrator to Complete This Portion Together

For Head Start Eligible families (100% of FPL or below)

Check if not applicable

I have been informed of my child's eligibility for Head Start and given the following:

- Contact information for the following Head Start location

BCIU Head Start

- Application and/or assistance with referral
- Brochure or website with information about Head Start
- I understand that my signature below indicates that I have been informed about my options for Head Start, and that I may choose to enroll in either the Pre-K Counts program or Head Start if eligible for both.

Parent/Legal Guardian (Signature)

Date



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Pre-K Counts Priority Rating Scale

Child Name: _____ D.O.B. _____ Date Completed: _____

The following criteria will be used to select children. If a risk factor is present, record points in Score Column.
If we have a wait list, the following rating scale will be used to prioritize enrollment. The highest score will receive first priority.

Criteria	Points	Score
Child entering Kindergarten next school year	25	
Child will get two years in Pre-K Counts	15	
Income (less than or equal to 200%)	25	
Income (more than 200% but less than or equal to 300%)	15	
Homeless: If any of the situations below apply a family is eligible under McKinney-Vento. -Is the family staying with others? -Is the family living in a shelter? -Is the family living in a motel, hotel or campground? -Is the family staying in a public or private place not ordinarily used as regular sleeping accommodation? -Is the family living in substandard housing? (limited or no utilities, unsafe conditions, etc.)	25	
Lives In High Poverty Area: A child who resides in a region with higher rates of poverty (including zip codes, school districts).	10	
English Language Learner: A child whose first language is not English and who is in the process of learning English.	25	
Child in or Part of Family in Child Welfare System: A child who is a foster child, a kinship care child or receiving Children and Youth Services.	25	
Child with a Behavior Support Plan from a mental health agency. A copy of the plan is required before enrollment.	25	
Child with an Individualized Education Plan (IEP) from an early intervention program. A copy of the IEP is required before enrollment.	25	
Concerns regarding child's physical development or existing medical condition (currently not receiving services)	15	
Concerns regarding child's speech or language development (currently not receiving services)	15	
Concerns regarding child's social, emotional or behavioral development (currently not receiving services)	15	
Incarcerated Parent-A child whose parent is currently incarcerated.	20	
Migrant/Seasonal Student-A child whose parent is currently a migratory agriculture worker	20	
Teen Parent-A child whose parent was under the age of 18 when the child was born	20	
Education Level of Guardian-A child whose parent or legal guardian does not have a high school diploma, high school equivalency or post-secondary degree.	20	
Family Living Structure-A child who resides with a single or divorced parent.	10	
Military Family-A child whose parent is on active duty or has a documented military service-related disability.	15	
Eligible for (or receives) the following public assistance: TANF, SSI, SNAP (documentation required)	10	
Enrolled in Infant Toddler Contracted Slots Program (ITCSP)	10	
Total		

FOR OFFICE USE ONLY

Income Verification

2026 Federal Poverty Level Guidelines Based On Annual Income

Family Size	100% (Head Start Eligible)	300% (Pre-K Counts Eligible)
1	\$15,960	\$47,880
2	\$21,640	\$64,920
3	\$27,320	\$81,960
4	\$33,000	\$99,000
5	\$38,680	\$116,040
6	\$44,360	\$133,080
7	\$50,040	\$150,120
8	\$55,720	\$167,160
Each Additional	+\$5,680 for each additional family member	+\$17,040 for each additional family member

Pay Frequency Calculation Guide:

Weekly	Multiply gross weekly income by 52
Bi-Weekly	Multiply gross income by 26
Semi-Monthly	Multiply gross income by 24
Monthly	Multiply gross income by 12

INCOME CALCULATION GRID

Name	Income Source	Pay Frequency	Gross Amount	Annualized Amount
1.				
2.				
3.				
4.				
Total Annual Income:			\$	_____

Actual Annual Verified Gross Household (Family) Income: \$ _____

*Attach copies of documents used to verify income prior to enrollment

Family Size (per PKC guidelines): _____

Family income is at or below 300% of federal poverty level relative to family size (required risk factor). Consider all sources of income. Must be verified prior to enrollment.

Staff Verifying Income and Risk Factors Signature

Date

Dual Enrollment Verification (Complete once eligibility and enrollment is confirmed)

This section helps process the PA PKC Verification Form, which documents a child's enrollment in the PA PKC Program and is submitted to the ELRC. Additionally, it ensures families seeking wraparound services receive referrals to the local ELRC and accurate notification of the PKC enrollment start date.

Is this child currently receiving CCW subsidy (at any program)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the family interested in receiving ELRC contact information to determine eligibility for CCW wrap around care (at any program)? Referral for ELRC # <u>13</u> Contact email or Phone number shared with family <u>484-651-8000</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the PA PKC program submitted a Verification Form to/communicated with the appropriate ELRC to confirm PKC enrollment with Child Care Works (CCW) and received confirmation back? Use the PA PKC and CCW dual enrollment contacts list on the PKC portal for this information	<input type="checkbox"/> Yes <input type="checkbox"/> No

Enrollment Outcomes: This section documents outreach, communication, and waitlist activity related to a child's application.

- Child enrolled – Date: _____ Child placed on waitlist – Date: _____
- Family declined placement – Date: _____ Unable to contact family after documented attempts

Documented Family Communication

Date	Communication Method	Purpose of Contact	Staff Initials
	<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Letter	<input type="checkbox"/> Application status <input type="checkbox"/> Waitlist update <input type="checkbox"/> Slot availability <input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Letter	<input type="checkbox"/> Application status <input type="checkbox"/> Waitlist update <input type="checkbox"/> Slot availability <input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Letter	<input type="checkbox"/> Application status <input type="checkbox"/> Waitlist update <input type="checkbox"/> Slot availability <input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Letter	<input type="checkbox"/> Application status <input type="checkbox"/> Waitlist update <input type="checkbox"/> Slot availability <input type="checkbox"/> Other: _____	

- Family was informed of waitlist status and next steps
- Family was informed they will be contacted when a slot becomes available