Note: All info shared with us is confidential... For office use only: #____ (   )

Over by:__________

ACAP EARLY HEAD START "SPECIAL DELIVERY" PROGRAM

7572 Court Street, Suite 2, PO Box 848
Elizabethtown, NY 12932
(518) 873-3207 Toll Free: 1-877-873-2979 Fax: (518) 873-6845

Mom's Name:______________________________ Mom's Date of Birth:________________

PO Box:________________ Street:__________________ Town:____________________

Zip Code:_______________ County:__________________ Telephone:________________

Mom's Status: Single:____ Married:_____ Divorced:_____ Separated:_____ Widow:_____

Are you covered by health insurance? No:_____ Yes:_____ What type:____________________

Are you receiving pre-natal care? No: _____ Yes:_____ Who is your provider:_____________

What is your estimated date of delivery:__________________

Are you experiencing any difficulties with your pregnancy? No:_____ Yes:_____ If yes, please explain:
____

When was your last OB/GYN appointment? ___________

Are you currently receiving WIC or any other ACAP services: No:___ Yes:___, Program(s)__________

Have you been referred to our program by another agency? No:_____ Yes:_____, by______________

Please list all persons living in your household:

First & Last Name	Relationship to You	Date of Birth
____________________	__________________	__________
____________________	__________________	__________
____________________	__________________	__________
____________________	__________________	__________
____________________	__________________	__________
____________________	__________________	__________
____________________	__________________	__________

Primary language spoken in home:______________________________

Secondary language spoken in home (if applicable):______________________________

FAMILY ETHNICITY: PLEASE CHECK APPROPRIATE CATEGORY

___ White/Caucasian
___ Asian
___ Black or African American
___ Other:______________________________
___ American Indian/Alaskan Native
___ Biracial/Multi-Racial
___ Native Hawaiian or other pacific Islander

MOM'S EMPLOYER:______________________________ PHONE #______________

ADDRESS: ______________________________

DAD'S EMPLOYER:______________________________ PHONE #______________

ADDRESS: ______________________________

HOW DID YOU LEARN ABOUT OUR PROGRAM:______________________________

Comments: (please tell us about any special concerns/diagnosed disabilities regarding you and your family):

____

____

____

Please give us directions to your home – either from the local Head Start site in your area, or from a known landmark/location in town: ______________________________

____

____

VERY IMPORTANT:

IN ORDER FOR YOUR APPLICATION TO BE PROCESSED, YOU *MUST* ATTACH A COPY OF YOUR INCOME VERIFICATION FOR THE FULL YEAR 2016. PLEASE ATTACH A COPY OF *ONLY THOSE ITEMS THAT APPLY TO YOU.*

- If you were employed at any time in 2016, submit a copy of all W-2 forms for 2016. If you submit a pay stub, it must be the last one received in 2016 indicating a "year-to-date" gross earned figure.
- If no W-2 forms, or pay stubs, and you were employed in 2016, submit a statement indicating the gross wages received in 2016, signed and dated by your employer(s), or, submit a copy of your 2016 income tax return.
- If you received Public Assistance/TANF benefits in 2016, submit a document from the Dept. of Social Services, indicating the total amount of benefits received in 2016.
- If you received any unemployment benefits in 2016, submit a document indicating total amount of benefits received in 2016.
- If you received any SSI benefits in 2016, submit a document indicating total amount of benefits received in 2016.
- If you received any Child Support in 2016, submit a document from the Support Collection Unit, or a signed statement from the person(s) paying you, indicating the total amount of support received in 2016.
- If you were self-employed in 2016, submit a copy of your "Schedule C" income tax return.

If no income verification is submitted, your application will be considered "pending". Pending applications cannot be processed, therefore, you cannot be considered for enrollment until all necessary info is received.

I understand that my financial circumstances and residential location will be considered when determining eligibility/placement. I certify that the above statements and the income information I have submitted are true and accurate, to the best of my knowledge. I agree to give my full support and cooperation by being ready and available for scheduled home visits, by attending group socializations/parent meetings, and by maintaining consistent communication with my Home Visitor.

Mom's Signature:______________________________ Date:______________

EHS/HS Staff Signature:______________________________ Date:______________

For staff use only:

Please initial:

Personal Interview: _____ (on site) _____ (home visit) Phone Interview: _____

Rec'd Ap by mail: _____

Notes:

PARENTS/GUARDIANS: COMPLETE THIS FORM ONLY IF YOU RECEIVED PUBLIC ASSISTANCE/TANF AT ANY TIME DURING THE FULL YEAR 2016. YOU MUST RETURN THIS FORM, ALONG WITH YOUR COMPLETED APPLICATION, TO THE FAMILY WORKER, OR HOME VISITOR FROM YOUR NEAREST HEAD START FACILITY.

CONSENT FOR VERIFICATION OF INFORMATION

State of New York | | Dept. of Social Services

Name/Address of Applicant	Social Service Dept.	Date

I, the undersigned, hereby give my consent to the above identified Dept. of Social Services, to verify information relating to my eligibility for Public Assistance as follows:

Names of Specific Contact (ACAP, Inc. staff member requesting this info & site address)

X________________________________Date__________
Signature of applicant/recipient

X________________________________Date__________
Signature of witness

(If signed with an X, a witness other than the caseworker or Dept. representative should be obtained)

PLEASE NOTE: INFORMATION REQUIRED TO DETERMINE ELIGIBILITY FOR THE ACAP, INC. EARLY HEAD START/ HEAD START PROGRAMS IS THE TOTAL AMOUNT OF BENEFITS RECEIVED FOR THE FULL YEAR 2016.

X________________________________
Signature of Caseworker or Dept. Representative