FOR OFFICE USE ONLY:

HS:_____

EHS:_____

REFERRED BY:_____

#_____( )

OVER BY:_____

****

ACAP, INC. HEAD START/EARLY HEAD START
7572 COURT STREET, SUITE 2 PO BOX 848
ELIZABETHTOWN, NY 12932
(518) 873- 3207
TOLL FREE: 1-877-873-2979 FAX: (518)873-6845

CHILD'S NAME:_____ DATE OF BIRTH:_____

MALE:_____ FEMALE:_____ AGE:_____

POST OFFICE BOX:_____ STREET (INCLUDE HOUSE NUMBER):_____

TOWN:_____ ZIP CODE:_____ COUNTY:_____

TELEPHONE: _____

PARENT(S)/GUARDIAN(S)_____

PARENT(S) STATUS: SINGLE_____ MARRIED_____ DIVORCED_____ SEPARATED_____ WIDOW(ER)_____

IS THIS CHILD IN FOSTER CARE WITH YOU: YES:_____ NO:_____

IS THIS CHILD COVERED BY HEALTH INSURANCE? YES:_____ NO:_____ TYPE:_____

ARE YOU CURRENTLY PREGNANT: YES:_____ NO:_____ EXPECTED DATE OF DELIVERY:_____

LIST ALL PERSONS IN HOUSEHOLD:

FIRST & LAST NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH (MUST PROVIDE)

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: _____

VERY IMPORTANT:

IN ORDER FOR YOUR CHILD'S APPLICATION TO BE PROCESSED, YOU *MUST* ATTACH A COPY OF YOUR INCOME VERIFICATION FOR THE FULL YEAR 2017. PLEASE ATTACH A COPY OF *ONLY THOSE ITEMS THAT APPLY TO YOU.*

- ⇨ IF YOU WERE EMPLOYED AT ANY TIME IN 2017, SUBMIT A COPY OF ALL W-2 FORMS FOR 2017. IF YOU SUBMIT A PAY STUB, IT MUST BE THE LAST ONE RECEIVED IN 2017 INDICATING A "YEAR-TO-DATE" GROSS EARNING FIGURE.
- ⇨ IF NO W-2 FORMS, OR PAY STUBS, AND YOU WERE EMPLOYED IN 2017, SUBMIT A STATEMENT INDICATING THE GROSS WAGES RECEIVED IN 2017, SIGNED AND DATED, BY YOUR EMPLOYER(S),OR, SUBMIT A COPY OF YOUR 2017 INCOME TAX RETURN.
- ⇨ IF YOU RECEIVED PUBLIC ASSISTANCE/TANF BENEFITS IN 2017, SUBMIT A DOCUMENT, FROM THE DEPARTMENT OF SOCIAL SERVICES, INDICATING THE TOTAL AMOUNT OF BENEFITS RECEIVED IN 2017.
- ⇨ IF YOU RECEIVED ANY UNEMPLOYMENT BENEFITS IN 2017, SUBMIT A DOCUMENT INDICATING TOTAL AMOUNT OF BENEFITS RECEIVED IN 2017.
- ⇨ IF YOU RECEIVED ANY SSI BENEFITS IN 2017, SUBMIT A DOCUMENT INDICATING TOTAL AMOUNT OF BENEFITS RECEIVED IN 2017.
- ⇨ IF YOU RECEIVED ANY CHILD SUPPORT IN 2017, 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 2017.
- ⇨ IF YOU WERE SELF-EMPLOYED IN 2017, SUBMIT A COPY OF YOUR "SCHEDULE C" INCOME TAX FORM

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

COMMENTS: (Please inform us of any special concerns/diagnosed disability regarding your child/family):

_____

_____

_____

_____

PLEASE GIVE ACCURATE DIRECTIONS TO YOUR HOME FROM THE EARLY HEAD START/HEAD START SITE IN YOUR AREA, OR FROM A KNOWN LANDMARK/LOCATION IN YOUR TOWN:

_____

_____

_____

APPROXIMATE NUMBER OF MILES (ONE WAY): _____

I WOULD LIKE THE ABOVE NAMED CHILD TO BE CONSIDERED FOR ENROLLMENT IN THE ACAP, INC. HEAD START OR EARLY HEAD START PROGRAM. I UNDERSTAND THAT MY CHILD'S AGE AND RESIDENTIAL LOCATION WILL BE CONSIDERED WHEN DETERMINING ELIGIBILITY/PLACEMENT. I CERTIFY THAT THE ABOVE STATEMENTS AND INCOME INFORMATION SUBMITTED ARE TRUE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE. I AGREE TO GIVE MY FULL SUPPORT AND COOPERATION BY VISITING THE SITE, VOLUNTEERING, ATTENDING PARENT MEETINGS, AND WELCOMING STAFF FOR HOME VISITS.

PARENT/GUARDIAN 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 2017. 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 2017.

X_____
Signature of Caseworker or Dept. Representative