FOR OFFICE USE ONLY **#** _____

HS: _____

EHS: _____ **OVER BY:** _____

REFERRED BY: _____

ACAP, INC. HEAD START/EARLY HEAD START
7572 COURT STREET SUITE 2 / P.O. BOX 848
ELIZABETHTOWN, NY 12932
(518) 873-3207
FAX: (518) 873-6845

CHILDS NAME: _____ **DATE OF BIRTH:** _____

MALE: ☐ **FEMALE:** ☐ **AGE:** _____

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

TOWN: _____ **ZIP CODE:** _____ **COUNTY:** _____

TELEPHONE: (HOME) _____ **(CELL)** _____ **(WORK)** _____

PARENT(S)/GUARDIANS: _____

PARENT(S) STATUS: SINGLE ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED** ☐ **WIDOWED** ☐

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 DELVIERY:** _____

LIST ALL PERSONS IN THE HOUSEHOLD:

FIRST & LAST NAME	**RELATIONSHIP TO CHILD**	**DATE OF BIRTH** Must Provide

PRIMARY LANGUAGE SPOKEN IN HOME (IF APPLICABLE): _____

SECONDARY LANGUAGE SPOKEN IN THE HOME (IF APPLICABLE): _____

FAMILY ETHNICITY: PLEASE CHECK THE APPROPRIATE CATEGORY:

☐ **WHITE/CAUCASION**
☐ **ASIAN**
☐ **BLACK OR AFRICAN AMERICAN**
☐ **AMERICAN INDIAN/ALASKAN NATIVE**
☐ **BIRACIAL/MULTI RACIAL**
☐ **NATIVE AMERICAN OR OTHER PACIFIC ISLANDER**

☐ **OTHER: _____**

MOTHER'S EMPLOYER: _____ PHONE #: _____

ADDRESS: _____

FATHER'S EMPLOYER: _____ PHONE #: _____

ADDRESS: _____

HOW DID YOU LEARN ABOUT OUR PROGRAM? _____

IMPORTANT INFORMATION:

IN ORDER FOR YOUR CHILD'S APPLICATION TO BE PROCESSED, YOU MUST ATTACH A COPY OF YOUR INCOME VERIFICATION FOR THE FULL YEAR 2020. IF YOU WERE EMPLOYED AT ANY TIME IN 2020, SUBMIT A COPY OF ALL W-2 FORMS FOR 2020. IF YOU SUBMIT A PAY STUB, IT MUST BE THE LAST ONE RECEIVED IN 2020 INDICATING A "YEAR-TO-DATE" GROSS EARNINGS FIGURE.

- **IF NO W-2 FORMS, OR PAY STUBS, AND YOU WERE EMPLOYED IN 2020, SUBMIT A STATEMENT INDICATING THE GROSS WAGES RECEIVED IN 2020, SIGNED AND DATED, BY YOUR EMPLOYER(S), OR SUBMIT A COPY OF 2020 INCOME TAX RETURN.**
- **IF RECEIVED PUBLIC ASSISTANCE/TANF BENEFITS IN 2020, SUBMIT DOCUMENTATION FROM THE DEPARTMENT OF SOCIAL SERVICES, INDICATING THE TOTAL AMOUNT OF BENEFITS RECEIVED IN 2020.**
- **IF YOU RECEIVED ANY UNEMPLOYMENT BENEFITS IN 2020. SUBMIT DOCUMENTATION INDICATING THE TOTAL AMOUNT OF BENEFITS RECEIVED IN 2020**
- **IF YOU RECEIVED ANY SSI BENEFITS IN 2020, SUBMIT DOCUMENTATION INDICATING THE TOTAL AMOUNT OF BENEFITS RECEIVED IN 2020.**
- **IF YOU RECEIVED ANY CHILD SUPPORT IN 2020, SUBMIT DOCUMENTATION FROM THE SUPPORT COLLECTION UNIT, OR SIGNED STATEMENT FROM THE PERSON(S) PAYING YOU, INDICATING THE TOTAL AMOUNT OF SUPPORT RECEIVED IN 2020.**
- **IF YOU WERE SELF-EMPLOYED IN 2020, 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 DOCUMENTATION 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 ACCIRATE, 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: _____

<u>For staff use only:</u>

Please initial:

Personal Interview: _____ _____ (on site)

_____ (home visit)

Phone interview: _____

Received Application by mail: _____

Notes:

PARENTS/GUARDIANS: COMPLETE THIS FORM ONLY IF YOU RECEIVED PUBLIC ASSISTANCE/TANF AT ANY TIME DURING THE FULL YEAR 2020. 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 VERIFCATION OF INFORMATION

State of New York		**Dept. of Social Services**
Name/Address of Applicant	**Social Services Department**	**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:

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

Signature of Applicant **Date**

Signature of Witness **Date**

(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 PROGRAM IS THE TOTAL AMOUNT OF BENEFITS RECEIVED FOR THE FULL YEAR 2020.

Signature of Caseworker or Dept. Representative