**FOR OFFICE USE ONLY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HS: \_\_\_\_\_**

**EHS: \_\_\_\_\_**

**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 E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IS THERE ANY LEGAL AND/OR COURT DOCUMENTATION WE SHOULD BE AWARE OF? YES: \_\_\_\_\_\_ NO: \_\_\_\_\_**

**LIST ALL PERSONS IN THE HOUSEHOLD:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FIRST & LAST NAME** |  | **RELATIONSHIP TO CHILD** |  | **DATE OF BIRTH**Must Provide |
|  |  | **Parent/Guardian 1** |  |  |
|  |  | **Parent/Guardian 2** |  |  |
|  |  | **Applicant** |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**PRIMARY LANGUAGE SPOKEN IN HOME (IF APPLICABLE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY LANGUAGE SPOKEN IN THE HOME (IF APPLICABLE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY ETHNICITY: PLEASE CHECK THE APPROPRIATE CATEGORY:**

 **\_\_\_\_\_ WHITE/CAUCASION \_\_\_\_\_ AMERICAN INDIAN/ALASKAN NATIVE**

 **\_\_\_\_\_ ASIAN \_\_\_\_\_ BIRACIAL/MULTI RACIAL**

 **\_\_\_\_\_ BLACK OR AFRICAN AMERICAN \_\_\_\_\_ NATIVE AMERICAN OR OTHER PACIFIC ISLANDER**

 **\_\_\_\_\_ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN 1’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN 2’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW DID YOU LEARN ABOUT OUR PROGRAM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOES YOU HAVE ANY CONCERNS WE SHOULD BE AWARE OF? YES: \_\_\_\_\_ NO: \_\_\_\_**

 **IF SO, PLEASE CHECK ALL THAT APPLY:**

**\*We ask about concerns to improve our ability to serve your children. None of these concerns disqualify your child from Head Start**

 **\_\_\_\_\_ DEVELOPMENTAL DISABILITY/SUSPECTED DEVELOPMENTAL DISABILITY**

 **\_\_\_\_\_ MENTAL HEALTH CONCERNS**

 **\_\_\_\_\_ BEHAVIORAL CONCERNS**

 **\_\_\_\_\_ SPEECH CONCERNS**

 **\_\_\_\_\_ PHYSICAL CONCERNS**

 **\_\_\_\_\_ HEARING CONCERNS**

 **\_\_\_\_\_ NUTRITION CONCERNS**

 **\_\_\_\_\_ SENSORY CONCERNS**

 **\_\_\_\_\_ EXPOSURE TO TRAUMATIC EVENTS**

 **\_\_\_\_\_ FAMILY CONCERNS**

 **\_\_\_\_\_ HOMELESSNESS OR UNSTABLE HOUSING**

 **\_\_\_\_\_ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU HAD ANY MAJOR CHANGES TO YOUR INCOME IN THE PAST 6 MONTHS? YES: \_\_\_\_ NO: \_\_\_**

**IF SO, PLEASE DESCRIBE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COMMENTS (Please inform us of any concerns):**

|  |
| --- |
|  |

**IMPORTANT INFORMATION:**

**IN ORDER FOR YOUR CHILD’S APPLICATION TO BE PROCESSED, YOU MUST ATTACH A COPY INCOME VERIFICATION FOR THE FULL YEAR \_2021\_\_\_\_. IF YOU WERE EMPLOYED AT ANY TIME IN \_\_2021\_\_\_, SUBMIT A COPY OF ALL W-2 FORMS FOR \_2021\_\_\_\_.**

* **IF NO W-2 FORMS, TWO PAYSTUBS ARE ACCEPTABLE**
* **IF NO W-2 OR PAYSTUBS, AND YOU WERE EMPLOYED IN \_2021\_\_\_\_, SUBMIT A STATEMENT INDICATING THE GROSS WAGES RECEIVED IN \_2021\_\_\_\_, SIGNED AND DATED, BY YOUR EMPLOYER(S), OR SUBMIT A COPY OF \_2021\_\_\_\_ INCOME TAX RETURN.**
* **IF RECEIVED PUBLIC ASSISTANCE/TANF BENEFITS IN \_2021\_\_\_\_, SUBMIT DOCUMENTATION FROM THE DEPARTMENT OF SOCIAL SERVICES, INDICATING THE TOTAL AMOUNT OF BENEFITS RECEIVED IN 2021\_\_\_\_\_.**
* **IF YOU RECEIVED ­ANY UNEMPLOYMENT BENEFITS IN \_2021\_\_\_\_. SUBMIT DOCUMENTATION INDICATING THE TOTAL AMOUNT OF BENEFITS RECEIVED IN \_2021\_\_\_\_**
* **IF YOU RECEIVED ANY SSI BENEFITS IN \_2021\_\_\_\_, SUBMIT DOCUMENTATION INDICATING THE TOTAL AMOUNT OF BENEFITS RECEIVED IN\_\_ 2021\_\_.**
* **IF YOU RECEIVED ANY CHILD SUPPORT IN \_2021\_\_\_\_, SUBMIT DOCUMENTATION FROM THE SUPPORT COLLECTION UNIT, OR SIGNED STATEMENT FROM THE PERSON(S) PAYING YOU, INDICATING THE TOTAL AMOUNT OF SUPPORT RECEIVED IN \_2021\_\_\_\_.**
* **IF YOU WERE SELF-EMPLOYED IN \_\_2021\_, 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.**

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE NOTE:**

* **Children are eligible to begin Head Start at the beginning of the school year if they turn 3 before December 1, 2022**
* **If a child turns 3 after December 1, 2022, they are eligible the day after their 3rd birthday**
* **If a child is 0-3 they are eligible for Early Head Start, which is a home visiting program**
* **Acceptance is based on a selection criteria and is on a need basis. Completion of this application does not guarantee acceptance. You will receive an acceptance or denial letter in August of 2022 if applying for Fall of 2022.**

**For staff use only:**

**Please initial:**

**Personal Interview: \_\_\_\_\_ \_\_\_\_\_ (on site)**

 **\_\_\_\_\_ (home visit)**

**Phone interview: \_\_\_\_\_**

**Received Application by mail: \_\_\_\_\_**

**Discussion of why we ask about concerns: Y:\_\_\_\_ N:\_\_\_\_\_**

**Notes:**

|  |
| --- |
|  |

**PARENTS/GUARDIANS: COMPLETE THIS FORM ONLY IF YOU RECEIVED PUBLIC ASSISTANCE/TANF AT ANY TIME DURING THE FULL YEAR \_\_\_\_\_. 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 \_\_\_\_\_.**

|  |
| --- |
|  |
| **Signature of Caseworker or Dept. Representative** |