

7572 Court Street Suite 2/P.O. Box 848 Elizabethtown, NY 12932

(518)873-3207 Fax: (518)873-6845

| Child's Name: Da | | Date of Bi | Date of Birth: | | |
|---|----------------------|-------------------|-------------------------------------|---------------------------------------|--|
| Male: Fema | ale: Female: | | Age: | | |
| Are you categorically eligible | ? (Please check | | and comple Foster Care: | | |
| Receive SNAP. | | Child is in | roster care. | | |
| Receive SSI or TANF: | Receive SSI or TANF: | | Child is Experiencing Homelessness: | | |
| Is your child a repeater in the | Head Start or Ea | arly Head Star | Program? _ | | |
| How did you learn about the p | orogram? | | | | |
| | | | | | |
| Contact Information | Parent/ Guard | Parent/ Guardian: | | Custodial Parent/ Guardian plicable): | |
| Address: (Street Number, Town, Zip Code, & County) | | | | | |
| Cell Phone Number: | | | | | |
| Home Phone Number: | | | | | |
| Work Phone Number: | | | | | |
| Email: | | | | | |
| Persons in household: | | | | | |
| First & Last Name: Relationship | | p to Child: | Dat | e of Birth: | |
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| Marital Status: | | | | |
|--|--|--|--|--|
| Is the child covered by h | nealth insurance? | | | |
| Are you currently pregn | ant? | | | |
| Do you have reliable tra | nsportation to get your child to school? | | | |
| Primary Language: | Secondary Langu | Secondary Language (If Applicable): | | |
| Family Ethnicity (Please White/Caucasian: Asian: Other: | check what applies): Black or African American: Biracial/Multi-Racial: | American Indian/ Alaskan Native: Native American or Pacific Islander: | | |
| | nployer: | | | |
| Address: | | | | |
| Parent/ Guardian (2) Er | mployer: | Phone: | | |
| Address: | | | | |
| | ns we should be aware of? This can he at applies) I have concerns about my cl Developmental Disability/ Suspected: | nild's: | | |
| Speech: | Physical: | Hearing: | | |
| Nutrition: | Exposure to Trauma: | Sensory: | | |
| Family: | Homeless/ Unstable Housing: | Other: | | |
| Have you had any major | changes in your income in the past 6 n | nonths? | | |
| 1 | PP | and the state of t | | |

In order for your child's application to be processed, you must attach income verification for the full priory year. Applications will be considered pending until income verification is submitted. How to verify income:

| W-2's | Two pay stubs | |
|--|--|--|
| Documentation of SNAP | Income tax return for | |
| Documentation of unemployment | Documentation of SSI | |
| Child Support | Documentation of TANF | |
| Statement of total wages signed and dated by | Self-employment- copy of "Schedule C" income | |
| your employer | tax form | |

I would like the above-named child to be considered for enrollment in ACAP, inc Head Start or Early Head Start. I understand that my child's age and residence will be considered when determining eligibility and placement. I certify the above statements and income 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: |
| Children are eligible to begin Head Start in September if they turn 3 If a child turns 3 after December 1st, they are eligible the day after the Children 0-3 are eligible for home-based Early Head Start. Completing this application does not guarantee a spot. Acceptance criteria, which is why it is important to fill the application to the best accurately depict your child and family. You will receive an acceptance or denial letter in August 2023 for the | neir 3 rd birthday. is based on selection t of your ability to |
| or 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: | |
| | |
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Parent/ Guardian: Complete this form only if you received public assistance (SNAP, SSI or TANF)at any time during the full 2022 year. You must return this form, along with a completed application, to the family worker or home visitor from your nearest Head Start program.

| Concont | for \ | /orificati | on of In | formation |
|---------|-------|------------|----------|-----------|
| Conseni | 101 | /erincan | on oi in | iormation |

| State of New York | | Dept. of Social Services |
|---|---|--|
| Name/Address of Applicant | Social Services Department | Date |
| | e my consent to the above ident my eligibility for Public Assistar | tified Dept. of Social Services, to nce as follows: |
| Name of Specific Contact (ACAP, Inc. staff member req | uesting this info & site address | |
| | | |
| | Ĭ | |
| Signature of Applicant | Date | |
| Signature of Witness | Date | |
| obtained). Note: Information required to o | other than the caseworker or l determine eligibility for ACAP, i f benefits received for the full y | inc Early Head Start/ Head Start |
| Signature of Caseworker or E | Dept. Representative | |