

Marital Status: _____

Is the child covered by health insurance? _____

Are you currently pregnant? _____

Do you have reliable transportation to get your child to school? _____

Primary Language: _____ Secondary Language (If Applicable): _____

Family Ethnicity (Please check what applies):

White/Caucasian:	Black or African American:	American Indian/ Alaskan Native:
Asian:	Biracial/Multi-Racial:	Native American or Pacific Islander:
Other:		

Employment:

Parent/ Guardian (1) Employer: _____ Phone: _____

Address: _____

Parent/ Guardian (2) Employer: _____ Phone: _____

Address: _____

Do you have any concerns we should be aware of? This can help improve our ability to serve your child. (Please check what applies) I have concerns about my child's:

Mental Health:	Developmental Disability/ Suspected:	Behavioral:
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 months? _____

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 your employer	Self-employment- copy of "Schedule C" income tax form

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.

Consent for Verification 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
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Signature of Witness	Date
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(If signed with an X, a witness other than the caseworker or Dept. representative should be obtained).
Note: Information required to determine eligibility for ACAP, inc Early Head Start/ Head Start program is the total amount of benefits received for the full year of 2022.

Signature of Caseworker or Dept. Representative