Adirondack Community Action Programs, Inc.

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Application Cover Sheet

Please check the box for the program option you want to be considered for below.

	Special Delivery Program: This program is part of Early Head Start. Home Visitors and Health Staff partner with expectant mothers through one-on-one support that meets individual needs and interests. This time is dedicated to prenatal and post-partum support.
	Early Head Start Center-Based: This year-round portion of the program is designed for children 18 months to 3-years-old. Our center-based programs are designed to support the social, emotional, nutritional, health, and educational needs of children within a classroom setting.
	Early Head Start Home-Based: Early Head Start Home-Based services are year-round and are designed for children 0-3. Home visits are conducted weekly through the entire year, focusing on education, nutrition, health, and family development. Group socializations occur twice monthly.
	Head Start Preschool Center-Based: This portion of the program is designed for children ages 3-5. Our center-based programs are designed to support the social, emotional, nutritional, health, and educational needs of children within a classroom setting. This program follows a typical school schedule.
	Head Start Home-Based: Head Start Home-Based services are for children 3-5. Home visits are completed weekly, following a typical school schedule, focusing on education, nutrition, health, family development, and kindergarten readiness. Group socializations occur twice monthly.

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Early Head Start/Head Start Application

Applicant Name: _____ Date of Birth: _____

Gender: _____ Age: _____

Please check any that apply to you:
Receive SNAP: _____ Child is in Foster Care: _____

Received SSI or TANF: _____ Currently Experiencing Homelessness: _____

Contact Information	**Guardian/Applicant:**	**Non-Custodial Parent/Guardian (If Applicable):**
Address: (Street Number, Town, Zip Code, and County)		
Cell Phone Number:		
Home Phone Number:		
Email:		

Persons in Household:		
First and Last Name:	**Relationship to Child:**	**Date of Birth:**

Have you been referred by another agency? _____

How did you learn about the program? _____

Is your child a repeater in the program? Yes: _____ No: _____ Not Applicable: _____

Are you currently receiving WIC or any other ACAP, Inc. services? If yes, which programs?

_____

Does your family receive child care subsidy? Yes: _____ No: _____

Marital Status of Parent/Guardian or Pregnant Mother:
Single: _____ Married: _____ Divorced: _____ Separated:_____ Widowed: _____

Please complete the questions in the box below if you are interested in Special Delivery:

Are you currently pregnant? Yes: _____ No: _____

Are you receiving pre-natal care?
Yes: _____ No: _____ Provider (If Applicable): _____

Expectant Date: _____ Last OB/GYN Appointment: _____

Are you experiencing any difficulties with your pregnancy? If yes, please explain:

_____

_____

Is the applicant covered by health insurance?
Yes: _____ No: _____ Provider (If Applicable): _____

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

Family Ethnicity (Please check all that apply):
White/Caucasian: _____ Asian: _____ Black or African American: _____

Biracial/Multi-Racial: _____ American Indian/Alaskan Native: _____

Native American/Pacific Islander: _____ Other: _____

Employment:
(1) Parent/Guardian or Applicant Employer: _____
Phone: _____ Address: _____

(2) Parent/Guardian or Applicant Employer: _____
Phone: _____ Address: _____

Have you had any major changes in your income in the past 6 months?

_____

Do you have any concerns we should be aware of? This can help improve our ability to serve the applicant. Please check what applies from the options below:

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

Speech: _____ Physical: _____ Hearing: _____

Nutrition: _____ Exposure to Trauma: _____ Sensory: _____

Family: _____ Homeless/Unstable Housing: _____ Other: _____

Do you have access to stable housing? _____

Do you have access to reliable transportation? _____

In order for this application to be processed, you must attach income verification for the full prior year. Additional consideration will be given to families whose housing costs exceed 30% of their income. Applications will be considered pending until income verification is submitted.

Possible items used to verify income:

W-2's	Two consecutive pay stubs
SNAP Documentation	Income tax return form
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

I would like the above, named applicant to be considered for enrollment in ACAP, Inc. Head Start or Early Head Start. I understand that my financial circumstances, residence, and child's age (if applicable) 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.

Guardian/Applicant Signature: _____ Date: _____

EHS/HS Staff Signature: _____ Date: _____

Important:

- Children are eligible to begin Head Start in September if they turn 3 before December 1st, 2025.
- If a child turns 3 after December 1st, they are eligible for Head Start the day after their 3rd birthday.
- Children 0-5 are eligible for home-based services.
- Completing this application does not guarantee a spot. Acceptance is based on selection criteria, which is why it is important to fill the application to the best of your ability to accurately depict your child and family.

For staff use only: Staff Initial: _____

Personal Interview:
On Site: _____ Home Visit: _____

Phone Interview: _____

Received Application by mail: _____

Notes:
_____

_____

_____

_____

_____