Early Head Start Child Care Partnership (EHS-CCP)
Application for Enrollment

Applications will only be reviewed once all the following is received:

➢ The child’s original birth certificate or other acceptable proof of age
➢ Proof of residency dated within the last 30 Days
➢ Photo identification for all parents/guardians in the child’s home
➢ Copy of the child’s most recent physical must be completed on SCAP form
➢ Copy of immunization records (SCAP form attached)
➢ Stamped Receipt from Day Care Assistance and/or Approval Letter
➢ If your child has health insurance include a copy of the insurance card with your application.
➢ If your household receives Supplemental Nutrition Assistance Program (SNAP) benefit, please submit a copy of your award letter with your application
➢ Documentation to verify ALL household income received in the previous year. Accepted Income verification documents includes:
   • Income Tax Forms (1040) *(preferred)*
   • W-2 Forms
   • Public Assistance
   • SSI Award Letter
   • Unemployment Compensation
   • Rental Property (If you have tenants that pay rent)
   • At least 4 pay stubs from the previous year with the year-to-date amount

Early Head Start - Child Care Partnership Office
920 Albany Street – 118 B
Schenectady, NY 12307
(518) 377-2015

SCAP EHS-CCP Sites
Andrea Adrian’ Day Care  Merari’s Day Care  Life’s Little Treasures  YWCA of Northeastern NY
Octavia Sanchez-Reyes Day Care  Munchkin University  SUNY Schenectady County Community College
First Parent/Guardian Information

First Name: ___________________________ Last Name: ___________________________
Date of Birth: ___________________________ Gender: ___________________________
Address: ________________________________________________________________
City: ___________________________ State: _______ Zip Code: ________________
Relationship to child: _________________________________________________
Phone Number: ___________________________ E-Mail address: ___________________________

Are you currently:

____ Attending School Where and what hours:

____ Working _______________________________________________

____ In a Training Program ___________________________________

Primary Language: ___________________________ Primary Ethnicity: Latino/Non-Latino (circle one)
Race: Asian / Black / Middle Eastern / Bi-Racial / Multi-Racial / Caucasian / Native American / Other (circle one)

Second Parent/Guardian Information

First Name: ___________________________ Last Name: ___________________________
Date of Birth: ___________________________ Gender: ___________________________
Address: ________________________________________________________________
City: ___________________________ State: _______ Zip Code: ________________
Relationship to child: _________________________________________________
Phone Number: ___________________________ E-Mail address: ___________________________

Are you currently:

____ Attending School Where and what hours:

____ Working _______________________________________________

____ In a Training Program ___________________________________

Primary Language: ___________________________ Primary Ethnicity: Latino/Non-Latino (circle one)
Race: Asian / Black / Middle Eastern / Bi-Racial / Multi-Racial / Caucasian / Native American / Other (circle one)
Child Information
First Name: ________________________ Last Name: ________________________
Date of Birth: ____________________ Gender: _____________________________
Address: _____________________________________________________________
City: _____________________________ State: ______ Zip Code: ________________
Primary Language: ________________ Primary Ethnicity: Latino/Non-Latino (circle one)
Race: Asian / Black / Middle Eastern / Bi-Racial / Multi-Racial / Caucasian / Native American / Other (circle one)
** Is the child enrolled in Parsons Early Head Start Program?     Yes_______ No_______

Is the mother/guardian currently pregnant?       YES_______ NO_______
Was the pregnancy with the child you are applying for considered high-risk?     YES_______ NO_______
Why: ________________________________________________________________
Was he/she born three or more weeks before the due date?  YES_______ NO_______

PLEASE LIST ALL OF THE PEOPLE THAT LIVE IN YOUR HOUSEHOLD IN THE SPACES PROVIDED BELOW:
If you need additional space, please attach a separate sheet of paper.

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Relationship To Applicant</th>
<th>Special Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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</tr>
</tbody>
</table>

Please Check All That Apply. Your Information Will Be Kept Confidential

<table>
<thead>
<tr>
<th>Special Needs</th>
<th>Child from EHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protective Services</td>
<td>Military Deployment</td>
</tr>
<tr>
<td>Medical Issues</td>
<td>Foster Child</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Grandparent Primary Caregiver</td>
</tr>
<tr>
<td>Incarcerated Parent</td>
<td>Parent Needs Interpreter</td>
</tr>
<tr>
<td>Drug or Alcohol Abuse</td>
<td>Receiving SCAP Services</td>
</tr>
</tbody>
</table>

Person to contact if we are unable to reach you:
First name: ________________________ Last name: ________________________
Phone #: __________________________ Relationship to child: ________________________
Does your child have health insurance?  
YES _______  NO _______

Check all that apply:

____ Medicaid
____ Child/Family Health Plus
____ Private Insurance
____ No Insurance
____ Other __________________________

Has your child ever been evaluated by Early Intervention Services?  
YES _______  NO _______

Is the child receiving any services for special needs or disabilities? Check all that apply:

____ Special Education  _______ Behavior
____ Occupational Therapy  _______ Speech
____ Physical Therapy  _______ Other

Do you have any concerns about your child’s development?

YES _______  NO _______

If yes, please explain: ____________________________________________________

___________________________________________________________

Does the child have any food or health restrictions?  YES _______  NO _______

Please list: _____________________________________________________________

____________________________________________________________________

Does anyone have concerns about the child’s health or development?  YES _______  NO _______

If yes, please explain: __________________________________________________

___________________________________________________________

Does the child have any siblings in:

____ Parsons Early Head Start  _______ SCAP Early Learning Program
____ YWCA  _______ Other __________________________

Please submit any one of the following documents to provide proof of income:

<table>
<thead>
<tr>
<th>Wage Statements (previous year)</th>
<th>Supplemental Security Income</th>
<th>Child Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Form</td>
<td>TANF Letter / PA Budget</td>
<td>Disability</td>
</tr>
<tr>
<td>Lottor From Employcr</td>
<td>Unemployment Lottor</td>
<td>Financial Aid / Grants</td>
</tr>
</tbody>
</table>

Please submit proof of your child’s age. Physical AND Immunization Records are REQUIRED before your child can attend

<table>
<thead>
<tr>
<th>Birth Certificate</th>
<th>Current Physical (w/in 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Card</td>
<td>Immunization Record</td>
</tr>
</tbody>
</table>

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

Parent/Guardian Signature __________________________  Date ___________
The Head Start Reauthorization Act

The Head Start Reauthorization Act has guidelines for providing services to homeless children and families. Please help us by answering the following questions.

**QUESTIONNAIRE**

Did you/your family recently move to Schenectady County?

___ YES ___ NO

When and for what reason: ________________________________________________

How long have you lived at the address provided on this application?

Do you:

___ Rent
___ Own your home

Please indicate which, if any, of the following situations apply to your family:

___ Family is sharing a residence with one or more families, relatives, or friends, temporarily
___ Family is living in a motel or hotel
___ Family is living in a shelter (domestic violence, emergency, or transitional housing unit)
___ Family is living in a car, park, campground, or other public place
___ Family is living in a place without adequate facilities (no running water, heat, electricity)
___ None of these apply

Is this temporary living arrangement due to loss of housing or economic hardship?

___ YES ___ NO

Please briefly explain your current situation:

____________________________________

____________________________________

____________________________________

____________________________________

Please note:

If a false claim is made about your living situation, enrollment may be effected. Please notify our office (518-377-8539) if your living status changes.

Parent’s Signature __________________ Date __________________
Early Head Start-Child Care Partnership Locations:

**Andrea Adrian's Day Care, Inc.**
434 Hulett Street
Schenectady, NY 12307
Phone: (518) 372-3081
Contact: Andrea Adrian

**YWCA Site 1**
44 Washington Avenue
Schenectady, NY 12305
Phone: (518) 374-3394 ext. 101
Contact: Nancy Johnson

**YWCA Site 2**
Schenectady County Community College
78 Washington Avenue
Schenectady, NY 12305
Phone: (518) 361-1375
Contact: Rebecca Fitch

**Life's Little Treasures**
235 Robinson Street
Schenectady, NY 12304
Phone: (518) 986-7723
Contact: Cydmarie Vargas (Gonzalez)

**Munchkin's University**
1074 Baker Ave
Schenectady, NY 12309
Phone: (518) 389-5779
Contact: Claire Morales

**Merari's Day Care**
352 Georgetta Dix Place
Schenectady, NY 12307
Phone: (518) 243-9081
Contact: Merari Gonzalez-Santiago

**Octavia Sanchez-Reyes Day Care**
714 Hattie Street
Schenectady, NY 12308
Phone: (518) 952-7395
Contact: Octavia Sanchez-Reyes
Schenectady Community Action Program Early Learning Centers
Child Well Care Medical Report

**ATTENTION PROVIDER: All components MUST be completed and immunization record attached**

This form follows AAP recommendations for Well Care Visits and NYS Health Dept. EPSDT Guidelines.

### Part 1: Child's Personal Information:
- **Child Name:**
- **Date of Birth:**
- **Parent/Guardian Name:**

### Part 2: Child's Health History, Examination, Results and Recommendations.

<table>
<thead>
<tr>
<th>Date of Exam:</th>
<th>BP:</th>
<th>Hem/Hgb Result:</th>
<th>Weight:</th>
<th>Height:</th>
<th>Did the child see a Dentist in last year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Nrml Abnl</td>
<td></td>
<td></td>
<td>Yes No Referred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Concerns:</th>
<th>Referred or Treated</th>
<th>Health Concerns:</th>
<th>Referred or Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Oral Health</td>
<td>[] None • Yes</td>
<td>Speech</td>
<td>[] None • Yes</td>
</tr>
<tr>
<td>Asthma</td>
<td>[] None • Yes</td>
<td>Vision</td>
<td>[] None • Yes</td>
</tr>
<tr>
<td>Development</td>
<td>[] None • Yes</td>
<td>Vision Acuity</td>
<td></td>
</tr>
<tr>
<td>Behavioral/Emotional</td>
<td>[] None • Yes</td>
<td>Left:</td>
<td></td>
</tr>
<tr>
<td>Learning/Attention</td>
<td>[] None • Yes</td>
<td>Hearing</td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>[] None • Yes</td>
<td>Type:</td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td>Result:</td>
<td></td>
</tr>
</tbody>
</table>

A. Significant health history, conditions, communicable illness or restrictions that may affect participation at school or play?
- [] None • Yes, please detail:

B. Significant allergies or health conditions that may require medication, special treatment, accommodations or emergency care at school?
- [] None • Yes, please detail: (Medication at school requires a separate consent and instructions from both the doctor and parent.)

C. Participation in Daily Activities: Diet and Activity Restrictions require a statement of condition and duration.
- Can child have a Regular Diet at school, including milk? [ ] Yes [ ] No, please detail:
- Can child participate in daily outdoor activity and gym exercise? [ ] Yes [ ] No, please detail:

### Part 3: Tuberculosis and Lead Exposure Risk Assessment and Testing

<table>
<thead>
<tr>
<th>TB</th>
<th>PPD Test Date:</th>
<th>Results:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>[ ] CXR Negative [ ] Treated, please detail any follow-up plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] CXR Positive [ ] No risk for TB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lead</th>
<th>Lead Test Date:</th>
<th>Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current if no previous test</td>
<td>[ ] Treated, please detail any follow-up plan</td>
<td></td>
</tr>
</tbody>
</table>

### Part 4: Required Provider Certification and Signature

On the basis of my findings, indicated above, and knowledge of the above named child, I find that: (s)he is up to date with NYS EPSDT guidelines free from contagious and communicable disease and is able to participate in all SCAP Early Learning Programs.

- [ ] Yes [ ] No

---

**Signature of Examiner**

**Address, City, State, Zip**

**Name (Please Print) and Title**

**Phone Number**

**Date:** (Continued on Back)
### Part 5: Immunization Information (please fill in or attach copy of immunization record)

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diptheria-Tetanus-Pertussis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Polio</td>
<td>1st</td>
<td>2nd</td>
<td></td>
<td>4th</td>
<td></td>
</tr>
<tr>
<td>Hemophilus Influenza B (HIB)</td>
<td>1st</td>
<td>2nd</td>
<td></td>
<td>3rd</td>
<td></td>
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<tr>
<td>Pevnmar</td>
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<td></td>
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<tr>
<td>Hepatitis B (HBV)</td>
<td>1st</td>
<td>2nd</td>
<td></td>
<td>3rd</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
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<tr>
<td>Measles-Mumps-Rubella (MMR)</td>
<td>1st</td>
<td>2nd</td>
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<tr>
<td>Varicella/Chicken Pox</td>
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</tbody>
</table>

**Other Immunizations:**

<table>
<thead>
<tr>
<th>Type of Immunization</th>
<th>Date</th>
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**Note:** Those children who have received at least one dose of each required vaccine and have an appointment schedule to receive the remainder of the required doses are considered "in process" of receiving the vaccines and may remain in school as long as the appointment schedule is kept and the parent provides verification the vaccines have been administered.

### FOR DOCTORS ONLY

**Medical Exemption:**

The physical condition of the child is such that one or more of the immunizations would endanger life or health.

<table>
<thead>
<tr>
<th>Signature of Doctor/Medical Provider</th>
<th>Date</th>
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Form Rev. 06-2022