



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

Applications will only be reviewed once *all* of 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 of 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 Include:
 - 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 paystubs 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's Day Care

Life's Little Treasures

YWCA of Northeastern NY

Merari's Day Care

Tenderfoot Daycare Center

SUNY Schenectady County Community College

First Parent/Guardian Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

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: _____

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: _____

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.**

Name:	DOB:	Relationship To Applicant:	Special Needs:
1.	___/___/___		
2.	___/___/___		
3.	___/___/___		
4.	___/___/___		
5.	___/___/___		
6.	___/___/___		
7.	___/___/___		

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

<input type="checkbox"/>	Special Needs	<input type="checkbox"/>	Child from EHS
<input type="checkbox"/>	Child Protective Services	<input type="checkbox"/>	Military Deployment
<input type="checkbox"/>	Medical Issues	<input type="checkbox"/>	Foster Child
<input type="checkbox"/>	Domestic Violence	<input type="checkbox"/>	Grandparent Primary Caregiver
<input type="checkbox"/>	Incarcerated Parent	<input type="checkbox"/>	Parent Needs Interpreter
<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	Receiving SCAP Services

Person to contact if we are unable to reach you:

First Name: _____ Last Name: _____

Phone Number: _____ 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:

<input type="checkbox"/>	Wage Statements (<i>Previous Year</i>)	<input type="checkbox"/>	Supplemental Security Income	<input type="checkbox"/>	Child Support
<input type="checkbox"/>	Tax Form	<input type="checkbox"/>	TANF Letter / PA Budget	<input type="checkbox"/>	Disability
<input type="checkbox"/>	Letter From Employer	<input type="checkbox"/>	Unemployment Letter	<input type="checkbox"/>	Financial Aid / Grants

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

<input type="checkbox"/>	Birth Certificate	<input type="checkbox"/>	Current Physical (within 12 months)
<input type="checkbox"/>	Benefit Card	<input type="checkbox"/>	Immunization Record

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

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) 381-1375
Contact: Rebecca Fitch

Life's Little Treasures

235 Robinson Street
Schenectady, NY 12304
Phone: (518) 986-7723
Contact: Cydmarie Vargas (Gonzales)

Merari's Day Care

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

Tenderfoot Daycare Center

451 Shannon Street, First Floor
Schenectady, NY 12306
Phone: (678) 760-3098
Contact: Adeyemi Bennett



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. (Please provide screening and testing results)

Date of Exam: _____ BP: _____ Hct/Hgb Result: Nrm Abn Weight: _____ Height: _____ Did the child see a Dentist in last year? Yes No Referred
 BMI: _____

Health Concerns:	Referred or Treated	Health Concerns:	Referred or Treated
Dental-Oral Health <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Speech <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Asthma <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Vision <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Development <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Vision Acuity Right: _____ Left: _____	
Behavioral/Emotional <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Hearing <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Learning/Attention <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Type: _____ Result: _____	
Language <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Neurologic <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX

A. Significant health history, conditions, communicable illness or restrictions that may affect participation at school or play?

None Yes, please detail: _____

Family Cardiac history Reviewed - required for Dominick Murry Sudden Cardiac Arrest Prevention Act Yes

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

TB PPD Test Date: _____ Results: _____ CXR Negative Treated, please detail any follow-up plan
 CXR Positive No risk for TB

Lead Lead Test Date: _____ Result: _____ Treated, please detail any follow-up plan
 Current if no previous test

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)

Diphtheria-Tetanus-Pertussis	1st	2nd	3rd	4th	5th
Polio	1st	2nd	3rd	4th	5th
Hemophilus Influenzae B (HIB)	1st	2nd	3rd	4th	
Prennar	1st	2nd	3rd	4th	
Hepatitis B (HBV)	1st	2nd	3rd		
Hepatitis A	1st	2nd			
Measles-Mumps-Rubella (MMR)	1st	2nd			
Varicella/Chicken Pox	1st	2nd			

Other Immunizations:

Type of Immunization:	Date:
Type of Immunization:	Date:

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.

Signature of Doctor/Medical Provider

Date

Do You Need Help Paying For Child Care?

Are You:

- Employed?
- Enrolled in a substance abuse treatment program?
- Looking for work?
- Enrolled in a job training or education program up to two-year college?

You May Be Eligible For Child Care Assistance!

Family Size	Annual Income Limit*	Monthly Income Limit
1	\$56,488.48	\$4,707.37
2	\$73,869.56	\$6,155.80
3	\$91,250.63	\$7,604.22
4	\$108,631.70	\$9,052.64
5	\$126,012.77	\$10,501.06
6	\$143,393.84	\$11,949.49

You Can Apply:

Online: www.sdlportal.com

Email: childcare@schenectadycountyny.gov

Fax: (518) 388-4536

Mail: Daycare Unit -388 Broadway -Schenectady, NY 12305

In Person: 388 Broadway Monday-Friday 8:30 AM -4:30 PM

Questions, call the Schenectady County Daycare Unit at (518) 388-4739.



**SCHENECTADY
COUNTY
CARES**