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SCAP
Schenectady Community Action Program
Creating Opportunity in Partnership

Andrea Adrian's Day Care

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

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

- A copy of the child's birth certificate or other acceptable proof of age
- Documentation to verify household income received the previous year
- Photo identification for parents/ guardians in the child's home
- Proof of residency dated within the last 30 Days
- Copy of the child's most recent physical (SCAP form attached)
- Copy of Immunization Records (SCAP form attached)
- Stamped Receipt From Day Care Assistance and/or Approval Letter

Accepted Documents:
Income Tax Forms (1040) **(preferred)**

W-2 Forms

Public Assistance

SSD or SSI Award Letter

Unemployment Compensation

Rental Property (If you have tenants that pay rent)

At least 4 Paystubs or Pay Envelopes from the previous year

Early Head Start - Child Care Partnership Office
837 Albany Street
Schenectady, NY 12307
(518) 377-2015

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 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			
	Special Needs		Child from EHS
	Child Protective Services		Military Deployment
	Medical Issues		Foster Child
	Domestic Violence		Grandparent Primary Caregiver
	Incarcerated Parent		Parent Needs Interpreter
	Drug or Alcohol Abuse		Receiving SCAP Services

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 / YMCA

_____ Other _____

Person to contact if we are unable to reach you:

First name: _____ **Last name:** _____

Phone #: _____ **Relationship to child:** _____

Early Head Start-Child Care Partnership Locations:

Andrea Adrian's Day Care

Andrea Adrian
434 Hulett Street
Schenectady, NY 12307
Phone:
(518) 372-3081

YWCA Site 1

44 Washington Avenue
Schenectady, NY 12305
Phone:
(518) 374-3394 ext. 101
Contact: Rebecca Fitch

YWCA Site 2

Schenectady County Community College
78 Washington Avenue
Schenectady, NY 12305
Phone:
(518) 381-1375
Contact: Rebecca Grunenwald

Please submit any one of the following documents to provide proof of income:					
	Wage Statements (previous year)		Supplemental Security Income		Child Support
	Tax Form		TANF Letter / PA Budget		Disability
	Letter From Employer		Unemployment Letter		Financial Aid / Grants

Please submit proof of your child's age. Physical AND Immunization Records are REQUIRED before your child can attend			
	Birth Certificate		Current Physical (w/in 12 months)
	Benefit Card		Immunization Record

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

_____ _____

Parent/Guardian Signature **Date**

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**

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: ☐ Nrml ☐ Abnl	Weight: Height: BMI: _____	Did the child see a Dentist in last year? ☐ Yes ☐ No ☐ Referred

Health Concerns:			Referred or Treated		Health Concerns:			Referred or Treated	
Dental-Oral Health	☐ None	☐ Yes	☐ Referred	☐ Under RX	Speech	☐ None	☐ Yes	☐ Referred	☐ Under RX
Asthma	☐ None	☐ Yes	☐ Referred	☐ Under RX	Vision	☐ None	☐ Yes	☐ Referred	☐ Under RX
Development	☐ None	☐ Yes	☐ Referred	☐ Under RX	Vision Acuity	Right: _____		Left: _____	
Behavorial/Emotional	☐ None	☐ Yes	☐ Referred	☐ Under RX	Hearing	☐ None	☐ Yes	☐ Referred	☐ Under RX
Learning/Attention	☐ None	☐ Yes	☐ Referred	☐ Under RX		Type: _____		Result: _____	
Language	☐ None	☐ Yes	☐ Referred	☐ Under RX	Neurologic	☐ None	☐ Yes	☐ Referred	☐ Under RX

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, accomodations 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

	PPD Test Date:	Results: _____ mm	☐ CXR Negative ☐ CXR Positive	☐ Treated, please detail any follow-up plan
TB				

	Lead Test Date:	Result:	☐ Treated, please detail any follow-up plan
Lead 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 guidlines 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)

Diptheria-Tetanus-Pertussis	1st	2nd	3rd	4th	5th
Polio	1st	2nd	3rd	4th	5th
Hemophilus Influenzae B (HIB)	1st	2nd	3rd	4th	
Prevnar	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 _____

FOR PARENTS ONLY

Religious Exemption:

In accordance with Public Health Law, the sincere religious beliefs of the child's parents prohibit immunization.

Do you wish to exercise those rights? ☐ Yes ☐ No

Any child not fully immunized for any reason must be excluded from care whenever there is an outbreak.
The child may return only upon approval of the local county health department.

Signature of Parent or Person Legally Responsible _____ Date _____

Form Rev. 07-2015