



Schenectady Community  
Action Program  
*Creating Opportunity in Partnership*

## Early Learning Program Initial Application for Enrollment 2020-2021 School Year

Due to facility closures as a result of COVID-19, the application process is temporarily modified. This is the initial application to get on our waitlist. At a later date, you will be contacted with instructions to submit additional documentation to verify eligibility. Email this application to [Jhalsdorf@scapny.org](mailto:Jhalsdorf@scapny.org)

### First Parent/Guardian Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-Mail address (**required**): \_\_\_\_\_  
Are you currently:  
\_\_\_\_ Attending School Where and what hours: \_\_\_\_\_  
\_\_\_\_ Working \_\_\_\_\_  
\_\_\_\_ In a Training Program

### Second Parent/Guardian Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-Mail address: \_\_\_\_\_  
Are you currently:  
\_\_\_\_ Attending School Where and what hours: \_\_\_\_\_  
\_\_\_\_ Working \_\_\_\_\_  
\_\_\_\_ In a Training Program

### Child Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

PLEASE LIST ALL OF THE PEOPLE THAT LIVE IN YOUR HOUSEHOLD IN THE SPACES PROVIDED BELOW:

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

**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

**Does your child have health insurance?**  
 YES \_\_\_\_\_ NO \_\_\_\_\_

**Check all that apply:**  
 Medicaid  
 Child/Family Health Plus  
 Private Insurance  
 Other \_\_\_\_\_

**Transportation** How will your child get to the Early Learning Program?  
 Car \_\_\_\_\_ Bus \_\_\_\_\_ Walk \_\_\_\_\_ Other: \_\_\_\_\_

**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: \_\_\_\_\_

**Person to contact if we are unable to reach you:**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

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

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date