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SCAP
Schenectady Community Action Program
Creating Opportunity in Partnership

Andrea Adrian's Day Care, Inc.

Life's Little Treasures

Heaven's Little Blessings

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
- 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 child's medical ID card
- Copy of Immunization Records (SCAP form attached)
- Stamped Receipt from Day Care Assistance and/or Approval Letter
- Documentation to verify 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

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.

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

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:					
	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 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.

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: Nancy Jones

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 (Gonzalez)

Heaven's Little Blessings

412 Paige Street
Schenectady, NY 12307
Phone: (518) 377-5877
Contact: Maria Estrada