Head Start Applications can be processed at any Head Start Center

ALBANY COMMUNITY ACTION PARTNERSHIP

Tel: 518.463.3175 ◆ Fax: 518.463.8185 or 518.432.6504
333 Sheridan Avenue ◆ Albany, New York 12206

Our Mission – *ACAP works in partnership with families and communities to empower people to achieve economic self-sufficiency and an improved quality of life.*

Head Start Pre- Enrollment Application Process for 2010-2011

Requirements:

Age eligibility- Head Start can only enroll children who will be 3 yrs. old by the first day of classes in Sept. 2010. If a child turns three after the first day of school, you must wait until their third birthday to apply for center programs. We can take your application earlier than the third birthday to apply for Home Based program or it will be considered for center placement when the child turns three.

Income eligibility: Head Start follows Income Guidelines set yearly by the Federal Government. Every application must include documentation of your yearly gross income to determine eligibility for Head Start.

UPK eligibility- school district residence and registration is required for 4 yr. old UPK classes.

Fill out the attached application completely and sign on the 4th & 5th pages. Bring the completed application and **all** of the documents listed below to the nearest Head Start center (**locations listed on next page**) or Main Office. Copies of your documents will be made and you will be given a receipt for your application. We will not accept incomplete applications.

1. Proof of Income –any of the following are acceptable - W-2 Income Statement (prior year tax form);Public Assistance Budget Sheet; four (4) weeks worth of employment pay stubs, Unemployment Payment Receipts, Child Support Payments, SSI Documentation, etc.
2. Child's Original Birth Certificate
3. Child's Medicaid and/or Health Insurance Cards (if child has coverage)
4. Child's current Immunization Record
5. Guardianship documents if applicable.

First Round Selection for enrollment is done in June. Center placement or Waiting List notifications are mailed to you in early July. All children must have a Head Start Physical Exam Form completed before s/he can begin attending classes in licensed sites. You will also receive a Head Start Dental Exam form to be completed by your child's dentist. You will receive information about your child's center Parent Orientation date and time with the placement notice.

If your child is placed at a center that provides transportation and/ or Extended Day services, you will fill out those request forms during Parent Orientation. Both of these services are very limited and are not guaranteed with acceptance. There is a fee for Extended Day services.

If you have any questions, please call the Head Start Program Center nearest you and speak with either a Family Development Specialist or Center Director; or you may call **Parent Involvement Coordinator**, at (518) 463-3175 extension 120 or **Quality Assurance** ext. 117.

Center Locations are listed on the next page.

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ALBANY CAP HEAD START LOCATIONS:		AGES	SERVICES AVAILABLE
Albany City School District Head Start UPK classrooms are located in the following elementary schools and Head Start Centers in Albany			
Arbor Hill Elementary School Arbor Drive Sheridan Prep Academy Head Start 400 Sheridan Ave. Schuyler Achievement Academy 676 Clinton Ave. Giffen Elementary School 274 So. Pearl St. North Albany Academy 570 No. Pearl St.		4	Must reside in Albany City School District and School District registration is necessary *before* placement
ACAP Early Learning Center 25 Monroe Street Albany, N.Y. 12210	(518) 463-0655	3 & 4	DSS funded Early Drop Off Extended Day Services for working or school enrolled parents 4 yr. olds must reside in Albany City School Districts School District registration is necessary *before* placement
Olivia Rorie Head Start 7 Morton Avenue Albany, N.Y. 12202	(518) 462-5411	3&4	4 yr. olds must reside in Albany City School District and School District registration is necessary *before* placement
Lincoln Square Head Start 3 Lincoln Square Albany, N.Y. 12202	(518) 436-0013	3&4	4 yr. olds must reside in Albany City School District and School District registration is necessary *before* placement
Ann Klose Head Start 295 Colonie Street Albany, N.Y. 12206	(518) 432-9622	3	
Head Start at Brighter Choice 250 Central Ave. Albany, NY 12206	(518) 694-4121	3	This classroom is not associated with the Brighter Choice Charter School system.
N. Albany YMCA Head Start Hannaford Early Childhood Center 616 N. Pearl St. Albany, N.Y. 12204	(518) 434-0816	3	
Ogden Mills Head Start One Ogden Plaza Cohoes, N.Y. 12047	(518) 237-1395	3&4	Home-Based option also available in Cohoes
BKW UPK Head Start Berne Knox Westerlo Elementary School Berne, N.Y. 12023	(518) 872-5127	4	Must reside in BKW School District School District registration is necessary *before* placement
Ravena Head Start Village Offices, 15 Mountain Rd. Ravena, N.Y. 12045	(518) 756-4602	3&4	
Watervliet Head Start 2400 Second Avenue Watervliet, N.Y. 12189	(518) 273-4329	3&4	Home-Based option also available in Watervliet
Watervliet Head Start/UPK Watervliet Elementary School Watervliet NY 12189	(518) 629-3411	4	Must reside in Watervliet School District School District registration is necessary *before* placement

Home Based Programs available in Cohoes, Watervliet and Hill Towns – call 463-3175 ext 117 for details

333 Sheridan Avenue, Albany, New York 12206
Tel. 518-463-3175 Fax 518-432-6504
www.albanycap.org

CUSTOMER INTAKE APPLICATION FORM

How did you hear about us?______________________________

Head of Household Name ________________________________ Sex: M ______ F _____ Date of Birth: / / ____________

Address: ________________________________ Social Security# _____-____-_________ Home Status: Do you ? Rent______ Own______

City, State: ______________ _____________ Zip Code _________________ Are You? : Buying______ Homeless_____

Phone: Home ____________________________________ Work ______________________________ Cell_________________________________

E-mail address: ____ Do you have a home computer? Yes _______ or No ______

Household Information: Number of parents in home: _____ Number of children in home: _____ Total family size: ______ **Family Type:** ______________________
(Male/Female single parent, single adult, Adults w/ child, Adults w/ no child, other)

List below *all* members of household: (Choices are listed in gray boxes)

First and Last Name:	**Date of Birth**:	**Sex**:	**Relationship to Head of Household** (self, spouse, child, foster child, grandchild, parent, grandparent, other relation or not related)	**Social Security Number**	**Language** Spoken in Home	**Ethnicity** Hispanic or Latino origin ? **Yes or No**	**Race**: (*list all*- Black/African Amer.; White; Asian; Amer. Indian or Alaska Native; Mix of two above--&--; Multi- racial; or Other
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			
	____/____/____			______-___-___________			

Albany Community Action Partnership and its programs do not permit any discrimination on the basis of color, race, sex, disability, religion or national origin.

WHAT TYPES OF SERVICES ARE YOU INTERESTED IN?

___HEAP ___ Head Start ___Child Care ___Income Tax Prep ___Weatherization ___Dress for Success ___Food Pantry ___Career Employment Services___Other _____________

List below *all* household members: (list multiple replies if they apply) **(Choices are listed in gray boxes)**

First and Last Name	**Does this person have Medical Insurance?** (Yes or No- If Yes, list type	**Is this Person Pregnant OR Disabled at this time?** (Yes or No- If yes, list which one or both)	**Is this Person a Veteran ? (Yes Or No)**	**Income sources** (Wages, PA/TANF, Retirement/Pension Food Stamps, SSI, Unempl. Comp., Veteran's Benefits Alimony/Ch. Supp, Social Security , Housing Assistance, Self-Employed, other	**Monthly Gross Income Amount** **Specify Amount From Each Income source**	**Documentation provided-**(pay stubs, W-2 from previous year, employer statement, PA budget sheet, Food Stamp budget sheet, SSI grant letter, Foster care grant letter, Social Security letter	**Marital Status-** Choose one- (Never married, Married, Separated ,Divorced, or Widowed)	**Employment Status-** (Full-Time Employed; Part-Time Employed; Unemployed; Seeking Work; Not available; Retired; Other)	**Is this Person Able to Work?** **Yes Or No**	**Education Level-** (0-8th grade; 9-12th grade; Non-High School Grad.; High School Grad GED; 12 plus some college or training cert.; 2 yr. college grad.; 4 yr. college grad.;

My signature verifies that I have willingly provided the information requested and that the information will be entered into the ACAP database to provide the best level of services that can be offered by ACAP.

Applicant Signature____ **Date** _______________________________________

Staff signature ___________________________________ Date __________________ Data entry completed date:_________________ Staff Initials _________

Head Start Enrollment Application 2010-2011

Name of Child:_______________________________________ Sex: M_____F______ Date of Birth:____/_____/_______

Name of Parent(s)/ Guardian(s) _________________________________ __ Mother __ Father __ Legal Guardian (Specify relation to child)__________ Lives in Home? Yes or No

_________________________________ __ Mother __ Father __ Legal Guardian (Specify relation to child)__________ Lives in Home? Yes or No

Home Address ____Zip Code________________

Phone Number: (Hm)____________________(Wk)_________________(Cell)__________________ E-mail address- ______________________________

Alternate Contact: Name______________________________ Phone _____________________ Relation to Parent ________________________________

Please check here if you're interested in requesting Extended Day Services: ____ OR Transportation Services: ______Center Preference:___________

Transportation and Extended Day Program placement are available on a limited basis and not at every center.
Center Placement will be guided by your home address & the services you request on this application and your eligibility for Head Start.
There is **no guarantee** your child will receive these services if accepted into the Head Start Program. Requests will be taken at Parent Orientation Sessions only.

Please speak with our Health / Nutrition Coordinator or Special Needs Coordinator at 463-3175 ext.112 or 137 re: any concerns about your child's development.

Do **you** feel your child has any Special and/ or Medical Needs such as: Speech ____ Hearing ____ Behavior ____ Emotional ____
Allergies __________ (Please list here ______________________________) Other (Please list)______________________

Has a doctor diagnosed any Special or Medical Needs? No _______ Yes _______ Please List_________________________

Is your child currently receiving any services? No _____ Yes _____ Please list ____

Will Head Start be used as day care for your child? No ____ Yes ____

Do you receive TANF Day Care Subsidies for your child? No ____ Yes ____ **If yes, please provide documentation.**

Has your child previously attended a preschool program? No ____ Yes ____ Where? _______________________________________

Is your child completely toilet trained? No ____ Yes ____

Have you had any other children enrolled in Head Start previously? No_____ Yes_____ Location ________________________________

Household Size: # of Parents ____ # of Children ____ Total ____

I understand that Head Start Program staff members will provide opportunities for periodic home visits and goal setting, and that my child will participate in all aspects of the Head Start Program unless restricted by documented medical or religious reasons.

Parent/ Guardian Signature ____ Date ___________________________

Staff Signature ____________________________________ Position ____________________ Date ___________________________

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Albany Community Action Partnership

HEAD START PROGRAM 2010-2011

Dental Examination Report

CHILD'S NAME: ______________________________ SEX: _____ BIRTH DATE: ____/____/____

PARENT(S) NAME: ______________________________ PHONE NUMBER: ______________

HEAD START SITE CHILD WILL ATTEND: ______________________________

I AGREE TO HAVE THIS INFORMATION RELEASED TO ACAP HEAD START- Parent Signature ______________________________

Date of Exam- ______________________

Diagnostic and Preventive Procedures Performed:

- ❑ Clinical Examination
- ❑ X-Rays
- ❑ Prophylaxis
- ❑ Fluoride application
- ❑ **Other** ______________________________

Current Status:

Cavities: ______________ (**How Many**) **Recurrent decay around old fillings:** ____________ (**How Many**)

Gums and supporting tissues:
- ❑ Normal & Healthy
- ❑ Slight Inflammation (gingivitis)
- ❑ Moderate Inflammation (gingivitis)
- ❑ Advanced disease (periodontitis)

Fluoride:________________ Other:______________________________

Recommendation:

- ❑ No further treatment recommended at this time. Return in ______________ months for an examination.
- ❑ Additional dental treatment is required. ❑ **Fluoride** ______________________________

Tooth # or letter	Description of Dental Services Required	Date & Description of Services Rendered

FORM MUST BE SIGNED BY DENTIST:

______________________ ______________________ __________

Dentist Name (Please Print) Signature Date

______________________________ ______________

Address, City, State & Zip Code Phone No.

2010-2011

[HeadStart Use Only:
[Approved by_________
[Date_____________

Albany Community Action Partnership Head Start Physical Exam Form

Enrollment Office- 333 Sheridan Ave. Albany, NY 12206
Phone- 463-3175 ext 117 Fax- 518- 432-6504

Child's Name:	Birth date:	**Date of Physical Exam**:
Are you this child's **Primary Care Physician**? Yes or No		

PHYSICIAN PLEASE NOTE: Federal Head Start Guidelines require information regarding this child's Hemoglobin, Lead Level and Blood Pressure. **If not done w/in one year, please indicate date and results from most recent test and indicate Current Risk**.

Hemoglobin:	Most recent date:	Result:	Current Risk? Yes or No
Lead:	Most recent date:	Result:	Current Risk? Yes or No
Blood Pressure	Date:	Result:	Current Risk? Yes or No

Height : **Weight**:	**Visual Acuity** R: L: Any concerns? No Yes	**Hearing**: R: L: Any concerns? No Yes

PHYSICAL EXAM	ABNORMALITIES?: NO	YES	DESCRIPTION
Head			
EENT			
Heart			
Lungs			
Abdomen			
Hernia			
Musculo-Skeletal			
Genitalia			
Skin			
Neurological			
Gait/Posture			

Important Health Problems	
Allergies: Yes No	If yes, list type & restrictions:
Daily Medications: Yes No	If yes, list type & dosage:
Nutritional Concerns: Yes No	If yes, please describe:
Developmental concerns: Yes No	If yes, please describe:
Mental Health: Yes No	If yes, please describe:
Disabilities: Yes No	If yes, please describe:
Asthma: Yes No	If yes, please describe:
Seizures: Yes No	If yes, please describe:
Diabetes: Yes No	If yes, please describe:
Describe any significant medical, surgical or illness history in past 2 years :	

Please attach child's immunization record to this form.
Are Immunizations up to date? Yes No If no, please list next appointment date:________________________

Recommendations for Treatment, Evaluations, Social and/or Educational Service:

Referrals made to:

On the basis of findings as indicated above and my knowledge of the child, I find this child to be physically fit and able to participate in all Head Start activities, unless otherwise noted.

Physician Name: ______________________________

Physician's signature________________________________Date of signature_____________________