Schenectady Community Action Program
Creating Opportunity in Partnership

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

Applications will only be reviewed once all 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 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 includes:
    - 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' Day Care | Merari's Day Care | Life's Little Treasures | YWCA of Northeastern NY
Octavia Sanchez-Reyes Day Care | Munchkin University | SUNY Schenectady County Community College

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.
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 (Gonzalez)

Munchkin's University
1074 Baker Ave
Schenectady, NY 12309
Phone: (518) 389-5779
Contact: Claire Morales

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

Octavia Sanchez-Reyes Day Care
714 Hattie Street
Schenectady, NY 12308
Phone: (518) 952-7395
Contact: Octavia Sanchez-Reyes

Schenectady Community Action Program

Creating Opportunity in Partnership

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 ☐ No risk for TB
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 _____

Form Rev. 06-2022