Schenectady Community Action Program

Creating Opportunity in Partnership

Early Learning Program

Application for Enrollment

Applications will only be reviewed once all of 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)
- 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

SCAP Early Learning Centers

Bigelow Avenue Early Learning Center 377-8539
100 Bigelow Avenue | Schenectady, NY 12304

Northside Village Early Learning Center 381-4195
2450 Van Vranken Ave Schenectady, NY 12308

Bellevue Early Learning Center 377-7300
2000 Broadway | Schenectady, NY 12306

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: _____

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: _____ 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

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)

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

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 concerns about your child's development?

YES _____ NO _____

If yes, please explain: _____
_____
_____

Does your child have health insurance?

YES _____ NO _____

If yes, please provide a copy of the insurance card with your application.

Check all that apply:

_____ Medicaid

_____ Child/Family Health Plus

_____ Private Insurance

_____ No 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: _____

_____

Does the child have any siblings in:

_____ Parsons Early Head Start _____ SCAP Early Learning Program

_____ YWCA _____ Other _____

Person to contact if we are unable to reach you:

First name: _____ Last name: _____

Phone #: _____ Relationship to child: _____

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**

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: ____/____/____ Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ____/____/____

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year ____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years ____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date