Children's Aid
Every step of the way

EARLY CHILDHOOD PROGRAMS – FULL ENROLLMENT APPLICATION

❑ BECC ❑CS211 ❑PS5 ❑ PS8 ❑PS152 ❑Drew Hamilton ❑ EHII/PS50 ❑Fred Doug ❑Taft ❑Richmond

I. PRIMARY CAREGIVER'S INFORMATION

1 Last Name: _____ First Name: _____ MI: ____

Gender: ❑ Female ❑ Male DOB: _____ Application Date: _____

2 Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Other Phone: _____

Email: _____

Do you consent to receive text messages and/or emails from Children's Aid? ❑ Yes ❑ No

3 Current Living Situation: ❑ Permanent Housing - has adequate living arrangements ❑ Homeless - living doubled-up; sharing a home as a result of loss of housing, economic hardship, or similar reason ❑ Homeless - living in a city shelter

4 Entitlements: check off any that are currently received ❑ TANF ❑ SSI ❑ SNAP ❑ WIC

Military Status: Are you an Active Member or Veteran of the US Military? ❑ Yes ❑ No

5 Health Insurance: Does the caregiver currently have medical insurance? ❑ Yes ❑ No

If yes, what type of medical insurance: ❑ Medicaid ❑ Private ❑ SCHIP

6 Pregnancy Status: Is a caregiver currently pregnant? ❑ Yes ❑ No If yes, what is the expected date of delivery? _____

Would the caregiver be interested in a Children's Aid Early Head Start program? ❑ Yes ❑ No

7 Ethnicity: Are you of Hispanic or Latino Origin? ❑ Yes ❑ No

Race: ❑ American Indian/ Alaskan Native ❑ Bi-Racial/Multi-Racial ❑ Native Hawaiian or Other Pacific Island ❑ Asian ❑ Black or African American ❑ White ❑ Other

Language: **If multiple languages, report both the Primary and Secondary*

❑ English ❑ African ❑ Caribbean ❑ East Asian ❑ European and Slavic ❑ Middle Eastern and South Asian ❑ Native Central American, South American, and Mexican ❑ Native North American/ Alaskan Native ❑ Pacific Islander ❑ Spanish ❑ Other: _____

8 Employment Status: ❑ Employed Full-Time ❑ Employed Part-Time ❑ Self- Employed ❑ Full-Time Job Training/School ❑ Part-Time Job Training/School ❑ Employed & Job Training/School ❑ Unemployed ❑ Retired or Disabled ❑ Home-Maker

9 Education Level: ❑ Bachelor or Advanced Degree ❑ College Degree or Training School Certification *(completed)* ❑ Some college or training school *(not complete)* ❑ High School Graduate ❑ Some High School ❑ No High School ❑ GED ❑ Professional Certificate or License ❑ Prefers Not to Answer

*Month/Year of Highest Education Level Completed: _____

10 Family Structure: ❑ Single Parent Household ❑ Two Parent Household

Best descriptor of this family: ❑ Mother ❑ Father ❑ Grandparent(s) ❑ Relative other than grandparent(s) ❑ Foster ❑ Other

What is the Family Size*?_____ Report their name(s), gender, DOB, and relationship below

**Family Size: all persons living in the same household who are supported by the caregiver's income; and are related by blood, marriage, or adoption.*

List the other family members reflected in your family size in the table below.

Name:	Gender:	DOB:	Relationship to Child:	Do they participate in any Children's Aid programming?
1.	❑ F ❑ M			
2.	❑ F ❑ M			
3.	❑ F ❑ M			
4.	❑ F ❑ M			
5.	❑ F ❑ M			
6.	❑ F ❑ M			
7.	❑ F ❑ M			
8.	❑ F ❑ M			

11 Is there a Court Order that prohibits or restricts any person from contact with the child?
❑ Yes ❑ No *If yes, please provide a copy of the Court Order to the staff.

12 How did you hear about Children's Aid Early Childhood programs?
❑ ChildrensAidNYC.org ❑ Children's Aid social media outlets (Facebook, Twitter, etc.) ❑ Community Event
❑ Community Partner or Agency Referral ❑ Family/Friend ❑ Former Parent ❑ Flyers/Posters

13 Children's Aid provides support for families enrolled in our programs. Are there areas of assistance you are interested in? (adult education, job training, parenting workshops, nutrition services, etc.)

II. SECONDARY CAREGIVER'S INFORMATION

14 Last Name: _____ First Name: _____ MI: ____
Gender: ❑ Female ❑ Male DOB: _____ Relationship to Child: _____

15 Home Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Other Phone: _____
Email: _____
Do you consent to receive text messages and/or emails from Children's Aid? ❑ Yes ❑ No

16 Health Insurance: Does the secondary caregiver currently have medical insurance? ❑ Yes ❑ No
If yes, what type of medical insurance: ❑ Medicaid ❑ Private ❑ SCHIP

17 Ethnicity: Are you of Hispanic or Latino Origin? ❑ Yes ❑ No

Race: ❑ American Indian/ Alaskan Native ❑ Bi-Racial/Multi-Racial ❑ Native Hawaiian or Other Pacific Island
❑ Asian ❑ Black or African American ❑ White ❑ Other

Language: **If multiple languages, report both the Primary and Secondary*
❑ English ❑ European and Slavic ❑ Native North American/ Alaskan Native
❑ African ❑ Middle Eastern and South Asian ❑ Pacific Islander
❑ Caribbean ❑ Native Central American, South American, and Mexican ❑ Spanish
❑ East Asian ❑ Other: _____

18 Employment Status:
❑ Employed Full-Time ❑ Full-Time Job Training/School ❑ Unemployed
❑ Employed Part-Time ❑ Part-Time Job Training/School ❑ Retired or Disabled
❑ Self- Employed ❑ Employed & Job Training/School ❑ Home-Maker

19 Education Level:
❑ Bachelor or Advanced Degree ❑ High School Graduate ❑ Professional Certificate or License
❑ College Degree or Training School Certification *(completed)* ❑ Some High School ❑ Prefers Not to Answer
❑ No High School
❑ Some college or training school *(not complete)* ❑ GED
*Month/Year of Highest Education Level Completed: _____

III. CHILD INFORMATION

20 Last Name: _____ First Name: _____ MI: ____

Gender: ❑ Female ❑ Male DOB: _____ Current Age: _____ Application Date: ___

21 Ethnicity: Is the child of Hispanic or Latino Origin? ❑ Yes ❑ No

Race: ❑ American Indian/ Alaskan Native ❑ Bi-Racial/Multi-Racial ❑ Native Hawaiian or Other Pacific Island
❑ Asian ❑ Black or African American ❑ White ❑ Other

Language: **If multiple languages, report both the Primary and Secondary*
❑ English ❑ European and Slavic ❑ Native North American/ Alaskan Native
❑ African ❑ Middle Eastern and South Asian ❑ Pacific Islander
❑ Caribbean ❑ Native Central American, South American, and Mexican ❑ Spanish ❑ Other: _____
❑ East Asian

* How well does the child understand English? ❑ Very Well ❑ Well ❑ Not Well ❑ Not at All

22 Disability Status: Does the child currently have an Active IFSP, an Active IEP, or a suspected disability? ❑ Yes ❑ No
If no, do you suspect your child may have a disability, developmental delay, or learning/behavioral challenges? ❑ Yes ❑ No

If yes, please share any concern: _____

_____

Has the child been referred for services or evaluation by the medical provider? ❑ Yes ❑ No

23 Has the child previously attended any Early Childhood programs? ❑ Yes ❑ No If yes, when: _____

IV. CHILD HEALTH INFORMATION

24 Health Insurance:
Does the child currently have medical insurance? ❑ Yes ❑ No If yes, what type of medical insurance: ❑ Medicaid ❑ Private ❑ SCHIP
Does the child currently have dental insurance? ❑ Yes ❑ No If yes, what type of dental insurance: ❑ Medicaid ❑ Private ❑ SCHIP

25 Provider Information:

Does the child have a medical provider that provides regular medical care (for illness, well-child checkups, etc.)? ❑ Yes ❑ No
Doctor/Clinic Name: _____
Doctor/Clinic's Address: _____
Phone: _____ Fax: _____

Does the child have a dentist who provides regular dental care? ❑ Yes ❑ No
Dentist/Clinic Name: _____
Dentist/Clinic's Address: _____
Phone: _____ Fax: _____

26 Immunization History: Is your child up-to-date on all immunizations appropriate for his/her age? ❑ Yes ❑ No

27 Medication, Asthma, Allergies, Intolerance, or Restrictions:
Does the child require medication to be administered while in school? ❑ Yes ❑ No
If yes, what medication and how often :_____
Has your child been diagnosed by a medical professional as having asthma? ❑ Yes ❑ No If yes, please complete the BRQ
Does your child have any food allergies or intolerance that require a special diet or substitutions prescribed by a doctor? ❑ Yes ❑ No
If yes, please describe: _____
** Note: Substitutions for medical reasons will be accommodated only with a signed statement from a licensed physician or other medical authority. Substitutions for non-medical reasons (i.e. religious, vegetarian, etc.) will be approved on a case-by-case basis with the Nutrition Manager or Nutritionist.*

Do you have any additional health concerns about your child?
Health (ie: recent hospitalization): _____
Dental (ie: cavities) : _____
Nutrition (ie: appetite, cultural requirements): : _____
Other: _____

By signing below, I certify that the information provided is true and correct to the best of my knowledge.

Sign: _____ Print: _____ Date: _____

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FOR AGENCY USE ONLY

EARLY CHILDHOOD PROGRAMS - ELIGIBILITY VERIFICATION FORM

❑ BECC ❑CS211 ❑PS5 ❑ PS8 ❑PS152 ❑Drew Hamilton ❑ EHII/PS50 ❑Fred Doug ❑Taft ❑Richmond

School Year: _____ Program Model: _____ Date: _____

Applicant's Name _____ Applicant's DOB: _____

1. Select the applicable type of eligibility:

❑ Categorically Eligible	❑ Income Eligible
❑ Recipient of Public Assistance (ex. TANF/SSI) ❑ Foster Care ❑ Homeless ❑ Doubled-Up/Over Crowded ❑ In City Shelter	❑ Income Eligible ❑ Over Income ❑ Above 130% FPL ❑ Between 100 - 130% FPL

2. What supportive document was used to determine eligibility?

Categorical Eligibility	Income Eligibility
❑ Public Assistance Budget/Award Letter ❑ Social Security Award/Benefits Letter ❑ Foster Care Verification Letter ❑ Homeless *(ACS Housing Questionnaire ECE-027)* ❑ Letter of Residency or Placement from homeless service provider agency.	❑ Income Tax Form 1040 ❑ W-2 Form ❑ Pay Stubs **3 months' worth of paystubs* ❑ Written statement from employer ❑ Unemployment Insurance ❑ Other: _____

3. Check off any of the following any additional eligibility criteria that apply

❑ Dual Language Learner ❑Recently Immigrated (w/i 12 months) ❑ Pregnant Parent
❑ Single Parent ❑ Teen Parent ❑An immediate family member is incarcerated ❑ Domestic Violence

Family Size: _____*
**Refer to full application for list of family members*

Total Annual Income: $_____

"I have reviewed the information provided to me from the applicant and have determined that the family is eligible to receive Early Head Start/ Head Start Services."

_____ _____
Family Advocate Signature Date

_____ _____
Supervisor Signature Date Verified