Dear Parent or Guardian:

Thank you for your interest in our program. We are pleased to provide you with an application for enrollment into our Head Start Program.

In order for us to determine your eligibility, we need to receive the following information as soon as possible:

- **Application** – *(Completed and signed)*

- **Proof of child’s age** *(such as birth certificate or other document with name and date of birth)*
  The child must be between 3 and 5 years of age.

- **Proof of total household income of Parent(s)/Guardian(s) of child:** *(all documents that apply)*
  Total gross wages, W-2 Tax statement *(s)*, signed 1040 tax forms; 12 Months of pay stubs; TANF/public assistance letter; Social Security payment *(all types)*; unemployment/worker’s compensation, Child support, Alimony.

  **If your family is homeless or your child is a foster care child:** Proof of Homelessness or Proof of Foster Care

  **If your child has been diagnosed with a disability:**
  Submit the child’s current Individualized Education Plan *(IEP)*; Individual Family Service Plan *(IFSP)* or recent information regarding special needs.

These documents must be submitted to us before your application can be processed. Please submit COPIES only. If you are unable to provide copies, the program staff can make copies for you.

Acceptance into the program is determined by Income, age and need using a point system. You will be notified of your child’s application status as soon as possible.

We look forward to receiving your Head Start application. If you need any assistance or clarification regarding the enrollment process, please call 845-343-4191 for Middletown/Scotchtown or 845-856-6821 for Port Jervis.

Sincerely,

Heather Decker
Director
RECAP HEAD START ENROLLMENT APPLICATION

240 Midland Lake Road
Middletown, NY 10941
(845)692-6567 Fax (845)692-6585

96 North Beacon Street
Middletown, NY 10940
(845)343-4191 Fax (845)956-1271

56-58 Church Street
Port Jervis, NY 12771
(845) 856-6821 (845) 858-8176 Fax

BASIC DEMOGRAPHIC DATA:

Child’s Name: __________________________ Date of Birth: ____/____/____ Gender _______

First Name __________________________ Last Name __________________________

Address: ________________________________________________________________

Street, Apartment number (If applicable) City State Zip Code

Home Phone #: __________________________ Cell #: __________________________ Other: __________________________

Ethnicity (check only one): [ ] Hispanic/Latino Origin [ ] Non-Hispanic/Non-Latino Origin

Race (check all that apply):

[ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American [ ] Native Hawaiian/Pacific Islander

[ ] White [ ] Hispanic/Latino [ ] Bi-Racial/Multi-Racial [ ] Other

Primary Language(s) family speaks in home: __________________________

How well does the child speak English?

[ ] Very Well [ ] Well [ ] Not Well [ ] Not At All

How well does the Family speak English?

[ ] Very Well [ ] Well [ ] Not Well [ ] Not At All

Has your child previously been enrolled in Early Head Start/Head Start? [ ] Yes [ ] No

Child previously applied or was on waiting list? [ ] Yes [ ] No

Do you currently have a child enrolled in Head Start? [ ] Yes [ ] No

SPECIAL NEEDS:

Does your child have a disability? [ ] Yes [ ] No If yes, does your child have an Individual education plan? [ ] Yes [ ] No

What type of disability does your child have? __________________________

Do you have any other concerns about your child’s overall health and development? [ ] Yes [ ] No

Describe concerns: __________________________

OTHER ELIGIBILITY INFORMATION: In order to determine if your family income is at or below the Federal poverty guidelines, we must know how many people are living in your household, as well as your family income. For our purposes, a family is “all persons living in the same household who are (1) supported by the income of the parent(s) or guardian(s) of the child enrolling in the program, and (2) related to the parent(s) by blood, marriage or adoption (3) the child’s authorized caregiver or legally responsible party.” (Performance Standards 45 CFR 1305.2)

How many people are in your household? _______ Please list all people in the family who are supported by the parents’ income:

<table>
<thead>
<tr>
<th>First and Last Name</th>
<th>Relationship to applicant/Child</th>
<th>Date of Birth</th>
<th>Employed (Yes or No) (Full time or part time)</th>
<th>In School (Yes or No) (Full time or Part-time)</th>
</tr>
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</tbody>
</table>

Parent/Guardian Signature __________________________ Date __________________________

Rev. 7/19/19 LDC
FID: ______ PID: ______

**FAMILY TYPE:** □ Biological Family □ Foster Family □ Other Relative □ Other family type

**PARENT STATUS:** □ Single Parent (mother figure) □ Single Parent (mother figure living w/partner) □ Single parent (father figure) □ Single Parent (Father figure living w/partner) □ Two Parent Family

**MARITAL STATUS:** □ Single □ Married □ Divorced □ Separated □ Spouse Deceased

**FAMILY INCOME:** Income must include the total gross income of all members of the family listed for either the past twelve months or for the previous calendar year. If neither the last 12 months nor the preceding year reflect your current financial situation, please be prepared to share information regarding this.

□ Yes □ No TANF (Temporary Assistance for Needy Families) □ Yes □ No Unemployment Benefits

□ Yes □ No SSI Supplemental Security Income □ Yes □ No Social Security Benefits (not SSI)

□ Yes □ No Child Support

**OTHER ASSISTANCE:**

□ Yes □ No Energy Assistance □ Yes □ No SNAP (Food Stamps)

□ Yes □ No WIC □ Yes □ No Medicaid

□ Yes □ No Subsidized housing (Section 8)

**ADDITIONAL INFORMATION:** Indicate any issues which have occurred to your child’s immediate family.

□ Military deployment □ Child abuse or neglect/Preventive Services (Open Cps case) □ Parent/Guardian diagnosed with developmental disability/mental health condition/long term illness □ Domestic Violence (within the last 24 mos.) □ Teen Mom □ Mom with less than High School education □ Substance abuse of adult family member □ Homelessness □ Foster care □ Incarcerated Parent (current or past 12 mos.) □ Primary Parent/legal guardian experienced abuse as a child

I was referred to Head Start by:

□ A professional □ A program □ Another Agency Please Explain: ____________________________

I found out about Head Start by:

□ A flyer □ Newspaper Ad □ Friend □ School □ Head Start Parent □ Social Media □ Other: ____________________________

The information provided will help us to determine your child’s eligibility for Head Start.

I hereby certify that I have provided all true, correct and complete income statements and information with this application. I understand that this information is being given in connection with the receipt of Federal funds; that institution officials may verify information; and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal status.

Parent/Guardian Signature: ____________________________ Date: __________

***************************************************************************** OFFICE USE ONLY*****************************************************************************

I verify I have seen proof of the income and certification of birth date and to the best of my knowledge is correct.

Interviewed/verified by: ____________________________ Date: __________

Reviewed by: ____________________________ Date: __________ Status: Incomplete App.

Not eligible _____, Eligible _____, Waitlist _____

Rev. 7/19/19 LDC
**RECAP Head Start Program Options**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Name:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Primary Language:</td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Future School District:</td>
<td></td>
</tr>
<tr>
<td>Receives Services:</td>
<td>Yes</td>
</tr>
<tr>
<td>Are there Siblings enrolled in:</td>
<td>Head Start</td>
</tr>
<tr>
<td>Close relative or friends are enrolled or employed at Head Start:</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you work/ Attend School /Job Training or Other Program?</td>
<td>Yes</td>
</tr>
<tr>
<td>What are your hours?</td>
<td></td>
</tr>
<tr>
<td>Who watches your child during this time?</td>
<td></td>
</tr>
<tr>
<td>Do you have access to reliable transportation while your child is in school?</td>
<td>Yes</td>
</tr>
<tr>
<td>How do you plan to transport your child to and from school?</td>
<td></td>
</tr>
<tr>
<td>Do you prefer:</td>
<td>Morning 8:00am-11:30pm</td>
</tr>
<tr>
<td>Would you like to be considered for our Full Day 6 ½ hour program?</td>
<td>Yes</td>
</tr>
<tr>
<td>If Yes, Why?</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

I understand that this information will assist the program in supporting the needs of my family and child. The program will try to meet my program preferences, depending on availability.

Parent /Guardian Signature ___________________________ Date ___________

Office Use Only:
☐ This family is in temporary housing ☐ Is interested in UPK ☐ This family has registered for UPK
☐ Port Jervis ☐ Middletown ☐ Scotchtown ☐ family resides within our transportation area FA Initials ___________
**RECAP Head Start**

**Child Well Care Medical Report**

This form follows AAP recommendations for Well Care Visits and NYS Health Dept. EPSDT Guidelines.

### Part 1: Child's Personal Information:

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Date of Birth</th>
<th>Parent/Guardian Name:</th>
</tr>
</thead>
</table>

### Part 2: Child's Health History, Examination, Results and Recommendations.

#### (Please provide screening and testing results)

<table>
<thead>
<tr>
<th>Date of Exam:</th>
<th>BP:</th>
<th>Hct/Hct Result:</th>
<th>Weight</th>
<th>Height:</th>
<th>Did the child see a Dentist in last year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nrl</td>
<td>Abnl</td>
<td></td>
<td>Nrl</td>
<td>Abnl</td>
</tr>
</tbody>
</table>

#### Health Concerns:

<table>
<thead>
<tr>
<th>Dental-Oral Health</th>
<th>None</th>
<th>Yes</th>
<th>Referred</th>
<th>Under RX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
<tr>
<td>Development</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
<tr>
<td>Behavioral/Emotional</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
<tr>
<td>Learning/Attention</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
</tbody>
</table>

#### Health Concerns

<table>
<thead>
<tr>
<th>Language</th>
<th>None</th>
<th>Yes</th>
<th>Referred</th>
<th>Under RX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
<tr>
<td>Vision</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
<tr>
<td>Hearing</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
<tr>
<td>Neurologic</td>
<td>None</td>
<td>Yes</td>
<td>Referred</td>
<td>Under RX</td>
</tr>
</tbody>
</table>

### 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, accommodations 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

#### TB Exposure Risk?

- [ ] High
- [ ] Low

#### PPD Test Date:

- [ ] Negative
- [ ] Positive

#### CXR Negative

- [ ] CXR Negative

#### Lead Exposure Risk?

- [ ] High
- [ ] Low

#### Lead Test Date:

- [ ] Result:

#### Treated, please detail any follow-up plan

### 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 free from contagious and communicable disease and is able to participate in school and daycare

- [ ] Yes
- [ ] No

__________________________
Signature of Examiner

__________________________
Name (Please Print) and Title

__________________________
Address, City, State, Zip

(____) ______
Phone Number Date
RECAP CHILD DENTAL HEALTH FORM

Participant: ____________________________

Date*: __________/________/________

PID: ____________________

FID: ____________________

Medical Provider: ____________________________

Completed by Staff: ____________________________

Type: [ ] Screening [ ] Examination

Type: [ ] Treatment

Dental Needs:

☐ No Needs ☐ Preventative Services ☐ Dental Treatment*

Preventative Services
(If selected above, please check from the following):

☐ Bitewing Films ☐ Cleaning ☐ Fluoride Supplement

☐ Fluoride Varnish ☐ Oral Hygiene Instruction ☐ Sealants

☐ Other (Please explain) ____________________________

Dental Services Received

Preventative Services Received*:

☐ Bitewing Films ☐ Cleaning ☐ Fluoride Supplement

☐ Fluoride Varnish ☐ Oral Hygiene Instruction ☐ Sealants

☐ Other (Please explain) ____________________________

Dental Services Received*:

☐ Fluoride Supplement ☐ Pulp Therapy ☐ Cleaning

☐ Extraction ☐ Restoration ☐ Oral Hygiene Instruction

☐ Other (Please explain) ____________________________

Treatment Not Received*:
(Reason for no Dental treatment)

Comments: ____________________________

Result of Follow-up:

☐ Below Expectations ☐ Passed

☐ Service Completed ☐ Service Nearly Complete

☐ Service not delivered ☐ Service Ongoing

Provider Signature: ____________________________