RECAP Head Start

Main Office
96 North Beacon Street
Middletown, NY 10940
(845) 343-4191
(845) 956-1271 Fax
Heather Decker, Director

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

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

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

FID: _____ PID: _____

RECAP HEAD START ENROLLMENT APPLICATION

240 Midland Lake Road
Middletown, NY 10941
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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:

First and Last Name	Relationship to applicant/Child	Date of Birth	Employed (Yes or No) (Full time or part time)	In School (Yes or No) (full time or Part-time)

Parent/Guardian Signature _____ Date _____

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____

RECAP Head Start Program Options

Child's Name: _____ **Date of Birth:**_____

Primary Language:_____Gender:_____

Address: _____

Future School District: _____ Receives Services: □Yes □No

Are there Siblings enrolled in: □ Head Start □ Another Preschool □ School District

Close relative or friends are enrolled or employed at Head Start: □Yes □No

Do you work/ Attend School /Job Training or Other Program? □Yes □No

What are your hours?

Who watches your child during this time?

Do you have access to reliable transportation while your child is in school? □ Yes □No

How do you plan to transport your child to and from school?

Do you prefer: □ ***Morning*** 8:00am-11:30pm or □ ***Afternoon*** 12:30pm-4:00pm

Would you like to be considered for our ***Full Day*** 6 ½ hour program? □Yes □ No

If Yes, Why?

Comments:

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:

Childs 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: ☐ Nrml ☐ Abnl	Hct/Hct Result: ☐ Nrml ☐ Abnl	Weight Height: ☐ Nrml ☐ Abnl	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	Language	☐ None ☐ Yes	☐ Referred	☐ Under RX
Asthma	☐ None ☐ Yes	☐ Referred	☐ Under RX	Speech	☐ None ☐ Yes	☐ Referred	☐ Under RX
Development	☐ None ☐ Yes	☐ Referred	☐ Under RX	Vision	☐ None ☐ Yes	☐ Referred	☐ Under RX
Behavioral/Emotional	☐ None ☐ Yes	☐ Referred	☐ Under RX	Hearing	☐ None ☐ Yes	☐ Referred	☐ Under RX
Learning/Attention	☐ 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, 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 Positive	☐ Treated, please detail any follow-up plan
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

Address, City, State, Zip

Name (Please Print) and Title

( ) Phone Number

Date

RECAP CHILD DENTAL HEALTH FORM

Participant: _____ PID: _____

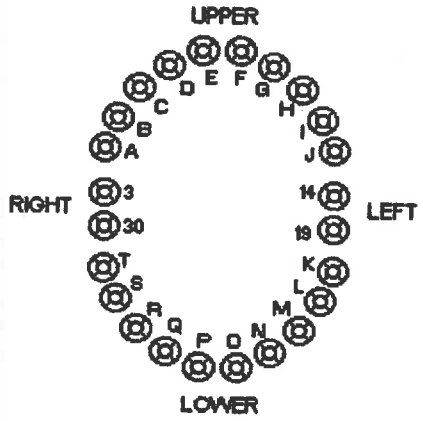
Date:*_____/_____/_____ FID: _____

Medical Provider: _____

Completed by Staff: _____

Type: ○ Screening ○ Examination

ORAL CONDITION



Missing
Decayed
Filled

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)

_____

_____

Type: ○ Treatment

Follow-Up Date: _____/_____/_____

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: _____