

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

Heather Decker,
Director

RECAP Head Start



Locations in:
Orange County
Middletown
Scotchtown
Port Jervis
and
Sullivan County
Woodbourne
Monticello

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 0 to 3 years old for early head start and 3 to 5 years of age for Head Start
- **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; SNAP/TANF/public assistance letter; Social Security payment (all types); unemployment/workers' compensation.

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 Program (IEP); Individual Family Service Program (IFSP) or recent information regarding special needs.

These documents must be submitted to us before we can process your application. 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 the main office at 845-343-4191.

Sincerely,

Heather Decker
Director



RECAP HEAD START/EARLY HEAD START ENROLLMENT APPLICATION

RECAP Head Start Locations:

RECAP Head Start in Orange County	RECAP Head Start and Early Head Start in Sullivan County:
240 Midland Lake Road, Middletown, NY 10941 Phone: 845-692-6567 Fax: 845-692-6585	104 Waverly Ave Monticello, NY 12701 Phone: 845-640-2078 Fax: 845-956-1271
96 North Beacon Street, Middletown, NY 10940 Phone: 845-343-4191 Fax: 845-956-1271	393 State Route 52 Woodbourne, NY 12788 Phone: 845-640-2078 Fax: 845-956-1271
56-58 Church Street, Port Jervis, NY 12771 Phone: 845-856-6821 Fax: 845-858-8176	

Applicant Information (Child or Pregnant Mother)

Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email address: _____

Primary Phone #: _____ Other Contact #: _____

Ethnicity (select 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

Language

Primary language(s) spoken at home: _____ Preferred language for communication: _____

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

Previous Head Start Experience

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

Child previously applied and/or was on the waiting list? Yes No

Child Health and Development

Does your child have any of the following needs? Check all that apply

- Food Allergies or intolerance
 Foods not eaten due to religious or personal reasons
 Environmental Allergies (e.g., medication, grass, insects/animals)
 Chronic Health Condition (e.g., asthma, seizures)
 Individual Education Program (IEP) or Early intervention services (IFSP)

• What services do they receive? _____

Do you have developmental concerns (e.g. speech, gross motor, fine motor, social-emotional) Yes No

Additional information about your child's needs:

Household Information: To determine if your family income is at or below 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)

List of all people in the family supported by the parents' income (including the child):

Name	Relationship	Date of Birth	Employed (Yes or No, Full Time or Part Time)	In School (Yes or No, Full Time or Part Time)

Total # of people in household: _____

Family Information:

Family Type: Biological Family Foster Family Other Relative Other: _____

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

Income and Assistance:

Does your family receive any of the following? (check all that apply):

TANF (Temporary Assistance for Needy Families) Unemployment Benefits SSI (Supplemental Security Income) Social Security Benefits SNAP (Food Stamps) Energy Assistance Subsidized Housing (Section 8) WIC Medicaid

Additional Family Circumstances

Check all that apply: Military deployment Child abuse or neglect (Open CPS case) Parent/Guardian diagnosed with mental health condition/long-term illness Domestic Violence (within last 24 months)
 Teen Parent Parent with less than High School education Substance use Temporary housing situation Foster care Incarcerated Parent Parent/Guardian experienced abuse as a child
 Death of Parent or Primary Caregiver 4 or more children under age 9 (current)

Referral Information

I was referred to Head Start by: Professional Program/Agency School

Name of professional or agency referring: _____

I heard about Head Start from: Flyer social media Friend Head Start Parent Other: _____

Certification: 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 statutes.

Parent(s) Signature: _____ Date: _____

(Office Use Only): "Verification of income and birth date has been completed, and I attest that the information appears accurate and complete."

Interviewed/Verified by: _____ Date: _____

Reviewed by: _____ Date: _____



RECAP HEAD START PROGRAM OPTIONS FORM



<p>Child's Name: <input style="width: 150px;" type="text"/> Date of Birth: <input style="width: 150px;" type="text"/></p> <p>Gender: <input style="width: 100px;" type="text"/> Primary Language: <input style="width: 150px;" type="text"/></p> <p>Address: <input style="width: 600px;" type="text"/></p> <p>Future School District: <input style="width: 150px;" type="text"/> Receives services: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Are there siblings enrolled in: <input type="checkbox"/> Head Start <input type="checkbox"/> Another Preschool <input type="checkbox"/> School District</p>
<p>Do you work/attend school/job training or another program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What are your hours?</p> <p>Who watches your child during this time?</p>
<p>Do you have access to reliable transportation while your child is in school? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How do you plan to transport your child to and from school?</p>
<p>Which center(s) are you interested in? (check all that apply)</p> <p><input type="checkbox"/> Monticello Center (Full Day Head Start and Early Head Start, self-transport only)</p> <p><input type="checkbox"/> Woodbourne/Riverside Center (Full Day Head Start and Early Head Start, self-transport only)</p> <p><input type="checkbox"/> Port Jervis Center (Full Day, Part Day AM/PM, UPK district transportation)</p> <p><input type="checkbox"/> Scotchtown Center (Part Day AM/PM transportation within busing area)</p> <p><input type="checkbox"/> Middletown Center (Full Day, Self-transport only)</p>
<p>Orange County ONLY:</p> <p>Do you prefer: AM <input type="checkbox"/> (8:00 am to 11:30 AM) or <input type="checkbox"/> PM (12:30 to 4:00 PM) <input type="checkbox"/> Either</p> <p>Would you like to be considered for our Full Day 6 ½ hour program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, why would you like to be considered?</p> <p>Which hours work best with your schedule?</p> <p><input type="checkbox"/> 8:30 am to 3:00 PM (MT only) <input type="checkbox"/> 9:00 and 3:30 PM (PJ or Middletown) <input type="checkbox"/> Either</p>
<p>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.</p> <p>Parent/Guardian Signature: <input style="width: 250px;" type="text"/> X Date: <input style="width: 150px;" type="text"/></p>
<p>Advocate Comments:</p>

Office use only: Family in temporary housing Interested in UPK Registered for UPK Family resides within transportation area Port Jervis Middletown Scotchtown

FA Initials _____



RECAP CHILD DENTAL HEALTH FORM

Participant: _____

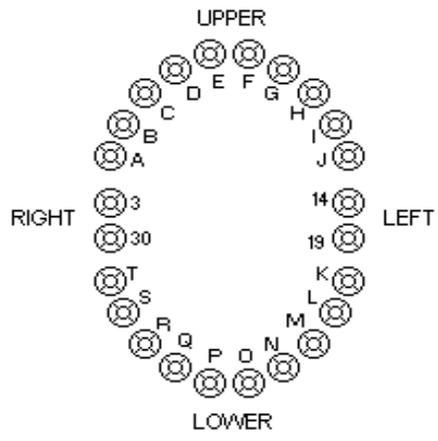
PID: _____

Date: * ____/____/____

FID: _____

Medical Provider: _____

Completed by Staff: _____

<p>Type: <input type="radio"/> Screening <input type="radio"/> Examination</p> <p>ORAL CONDITION</p> <div style="text-align: center;">  </div> <p>Dental Needs:</p> <p><input type="checkbox"/> No Needs <input type="checkbox"/> Preventative Services <input type="checkbox"/> Dental Treatment*</p> <p>Preventative Services (If selected above, please check from the following):</p> <p><input type="checkbox"/> Bitewing Films <input type="checkbox"/> Cleaning <input type="checkbox"/> Fluoride Supplement</p> <p><input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Oral Hygiene Instruction <input type="checkbox"/> Sealants</p> <p><input type="checkbox"/> Other (Please explain) _____</p> <hr/> <p style="text-align: center;">STAMP</p> <hr/>	<p>Type: <input type="radio"/> Treatment</p> <p>Follow-Up Date: _____/_____/_____</p> <p>Dental Services Received</p> <p>Preventative Services Received*:</p> <p><input type="checkbox"/> Bitewing Films <input type="checkbox"/> Cleaning <input type="checkbox"/> Fluoride Supplement</p> <p><input type="checkbox"/> Fluoride Varnish <input type="checkbox"/> Oral Hygiene Instruction <input type="checkbox"/> Sealants</p> <p><input type="checkbox"/> Other (Please explain) _____</p> <p>Dental Services Received*:</p> <p><input type="checkbox"/> Fluoride Supplement <input type="checkbox"/> Pulp Therapy <input type="checkbox"/> Cleaning</p> <p><input type="checkbox"/> Extraction <input type="checkbox"/> Restoration <input type="checkbox"/> Oral Hygiene Instruction</p> <p><input type="checkbox"/> Other (Please explain) _____</p> <p>Treatment Not Received*: (Reason for no Dental treatment) _____</p> <p>_____</p> <p>Comments: _____</p> <p>_____</p> <p>Result of Follow-up:</p> <p><input type="checkbox"/> Below Expectations</p> <p><input type="checkbox"/> Passed</p> <p><input type="checkbox"/> Service Completed</p> <p><input type="checkbox"/> Service Nearly Complete</p> <p><input type="checkbox"/> Service not delivered</p> <p><input type="checkbox"/> Service Ongoing</p>
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Provider Signature _____



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:

Child's Name:	Date of Birth:	Parent/Guardian Name:
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Part 2: Child's Health History, Examination, Results and Recommendations. (Please provide screening and testing results)

Date of Exam:	BP: <input type="checkbox"/> Nrmal <input type="checkbox"/> Abnl	Hgb Result: <input type="checkbox"/> Nrmal <input type="checkbox"/> Abnl	Weight	Height: <input type="checkbox"/> Nrmal <input type="checkbox"/> Abnl	Did the child see a Dentist in last year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred
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Health Concerns:	Referred or Treated	Health Concerns	Referred or Treated
Dental-Oral Health <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Language <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Asthma <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Speech <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Development <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Vision <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Behavioral/Emotional <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Hearing <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Learning/Attention <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Neurologic <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> 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?	<input type="checkbox"/> High <input type="checkbox"/> Low	PPD Test Date:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	<input type="checkbox"/> CXR Negative <input type="checkbox"/> CXR Positive	<input type="checkbox"/> Treated, please detail any follow-up plan
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Lead Exposure Risk?	<input type="checkbox"/> High <input type="checkbox"/> Low	Lead Test Date:	Result:	<input type="checkbox"/> Treated, please detail any follow-up plan
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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

_____ <i>Signature of Examiner</i>	_____ <i>Address, City, State, Zip</i>
_____ Name (Please Print) and Title	_____ Phone Number
	_____ Date