FULMONT COMMUNITY ACTION AGENCY, INC.
EARLY CHILDHOOD SERVICES
HEAD START APPLICATION

PLEASE CALL 1-800-958-8225 TO MAKE ARRANGEMENTS TO HAVE YOUR APPLICATION PICKED UP OR DROPPED OFF AT ONE OF OUR LOCATIONS.

PARENT'S CHECKLIST FOR ENROLLING AT HEAD START:

Please be aware that the following items must be submitted before your child can be accepted: Application completed and signed. All lines must be filled out completely or marked "does not apply" (NA)

- *Income (Below is a list of acceptable proof of income for one year):*
    - *Tax return*
    - *Last pay stubs of the year outlining your year to date salary*
    - *Employer statements on letter head outlining your annual income for the previous year*
    - *TANF printout*
    - *SNAP printout*
    - *SSI printout*
    - *Disability printout*
    - *Social Security*
    - *Unemployment printout*
    - *Child support (either court order or notarized letter stating amount received)*
    - *Rental income*
    - *If you were not employed, you must submit a notarized letter stating the time period you were not employed.*
- *Copy of child's birth certificate*
- *Copy of child's immunization record*

All information is kept confidential

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Child's Full name: ______________________________ Date of Birth: ______________

Gender: ☐ Female ☐ Male Primary Language: ______________ Other Language: ______________

Public School District: ______________________________

Family Type:

☐ Single Parent ☐ Two Parents ☐ Foster Parent ☐ Formal Custody

Parental Status:

☐ Married ☐ Separated ☐ Single ☐ Divorced

Parent/Guardian Name: ______________________________ Date of Birth: ______________

Cell Phone #: ______________ Home #: ______________ Email address: ______________

Primary Address: ______________________________

Employed: ☐ Yes ☐ No If yes, Place of Employment ______________ Phone # ______________

Primary Language: ______________ Other Language: ______________ Which language do you read and write: ______________

Parent/Guardian Name: ______________________________ Date of Birth: ______________

Cell Phone #: ______________ Home #: ______________ Email address: ______________

Primary Address: ______________________________

Employed: ☐ Yes ☐ No If yes, Place of Employment ______________ Phone # ______________

Primary Language: ______________ Other Language: ______________ Which language do you read and write: ______________

Family Services Received:

☐ TANF ☐ WIC
☐ Food Stamps

Medical Insurance:

☐ Yes
☐ No

Type of Insurance:

☐ Medicaid ☐ Family Health Plus ☐ Military ☐ Private
☐ Combined Medicaid with Fidelis or CDPHP ☐ Other

Does child or any family member have any diagnosed disabilities or health needs? ☐ Yes ☐ No

Name? ______________________ Describe diagnosed disability/Health need: ______________________

Name? ______________________ Describe diagnosed disability/Health need: ______________________

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How did you hear about Head Start?

☐ Road Sign ☐ Facebook ☐ ECS Staff contacted me ☐ Other ____________________
☐ Brochure ☐ Community Event
___ by home visit
___ by phone call

Do you have transportation? ☐ Yes ☐ No

Is your family experiencing any present difficulties? ☐ Yes ☐ No If yes, please explain: ______________________________

HOUSEHOLD

Name	Date of Birth	Relationship to child

Is anyone living within the household listed on the NY State Sex Offenders Registry? ☐ Yes ☐ No

If yes, who? ____

Source of Income:	**Check off all that apply to you or family members:**
☐ Employment ☐ Child Support ☐ Alimony	☐ Deceased Parent ☐ Parent in School/Training
☐ Foster Care ☐ Unemployment Benefits	☐ Substance Abuse ☐ Parent in US Military
☐ Pension ☐ Other __________________	☐ Incarceration Name? ______________________________
☐ SSI ☐ SSD	

PLEASE CHECK WHICH PROGRAM YOU WOULD LIKE YOUR CHILD TO BE ENROLLED IN:

- ☐ **Amsterdam**
- ☐ **Gloversville**
- ☐ **OESJ**
- ☐ **Johnstown**
- ☐ **Mayfield**

***** I hereby attest that the information collected on this form is true and accurate to the best of my knowledge*****

____ ____

Applicant Signature *Date* *ECS Staff Signature* *Date*

I, ____, give permission for the Fulmont Early Childhood Services Health Staff to obtain my child _______________________________immunizations records from the NYS database.

________________________________ ________________________

Print Name Date

________________________________ ________________________

Signature Date

HOUSING QUESTIONNAIRE

Name of Child: ____

Gender: ( ) Male ( ) Female Date of Birth: ____/_____/_______

Address:___________________________________ Phone Number:_________________

____

NOTE TO PARENTS:
Children who are living in temporary housing can enroll in and begin attending Head Start programs right away, even if they don't have the documents normally needed for enrollment (such as proof of address/residency, immunizations records, or birth certificate). Parents of children in temporary housing must be given reasonable time to hand in these documents. In the meantime, the children can enroll and participate in program. Children who are living in temporary housing also get priority for enrollment.

The answer you give below will help the Head Start program determine whether your child is in temporary housing and eligible for these benefits.

The answer you give will be kept confidential as much as possible and will only be shared with staff providing services to your child and those who have to keep track of how many children in the Head Start program are in temporary housing.

Where is your child currently living? (*Please check* *one* *box)*

- ☐ With another family or other person because of loss of housing, economic hardship or similar reason (also called temporarily living "doubled-up")
- ☐ In a shelter
- ☐ In a hotel or motel
- ☐ In a car, park, bus or train station, or campsite
- ☐ Other temporary living situation
  (Please describe):____
- ☐ In a home that our family owns or rents

____ ______________________

Signature of Parent or Guardian Date

Fulmont Community Action Agency* Inc,
Head Start
208 Truax Road
Amsterdam, NY 12010
Phone (518)842-8225 Fax(518) 842-1419

Consent to Release/Obtain Confidential Information

I______________________________ do hereby consent to and

Authorize Fulmont Community Action Agency Head Start Program to obtain from and release to:

____

Name of

(Doctor/speech therapist/community organization etc.)

____

(address)

________________________ ________________________

(phone number) (fax number)

________________________ ________________________

Child's Name Child's Date of Birth

This consent for the above named child entities Fulmont Community Action Agency Head Start to share medical records, information, etc. with the above named Service Provider, Iunderstand that the above information can only be discussed with this written consent .The duration of this authorization is valid for the entire school year. I understand that I may revoke this consent at any time by notifying Head Start in writing.

________________________ ________________________

(Guardian Signature) (Date)