Economic Opportunity Program, Inc.
Strengthening the fabric of our community

EOP BIRTH TO 5 SCHOOL READINESS PROGRAM
HOME BASED
APPLICATION

Items Needed for Completion of Application

- ❖ Completed Application
- ❖ Proof of Current Address
- ❖ Copy of Child's Birth Certificate
- ❖ Copy of Child's Medical Insurance Card
- ❖ Signed Pediatric Medical Release Form Provided in the application
- ❖ Completed Medical Statement (Please take this form to your child's physician for completion)
- ❖ Custody Papers (if Applicable)
- ❖ Copy of Child's SSI eligibility(if Applicable)
- ❖ Verification of Income:
  - Last year's Tax Returns, W2's or 12 months of Pay Stubs
  - See next page if you have questions
- ❖ Most Recent Dental Record if available

You may Drop off, Mail or Fax your completed application to:

Enrollment Facilitator
650 Baldwin Street
Elmira, NY 14901
Fax: 607-733-0598

Please call with any questions:
Amy Willette, Manager ERSEA Services
(607) 734-6208, ext. 276

As part of the application process, the Home Based Programs must verify family income before determining if the child is eligible. Head Start/Early Head Start eligibility is based on numerous factors including living status, income and family need.

INCOME INCLUDES

- Tax Returns (form 1040)
- W2's
- 12 Months of Pay Stubs
- Social Security
- TANF(Temporary Assistance for Needy Families)
- Unemployment Compensation
- Child Support
- Alimony
- Worker's Compensation
- College or University Scholarships, Grants, Fellowships & Assistantships
- Other Regular Support from an absent family member not living in the household
- Pay Stubs or salary before deductions
- Unemployment Compensation
- Cash Receipts before taxes
- Strike benefits from union funds
- Veteran's Benefits
- Training Stipends
- Military Family Allotments
- Net Gambling or Lottery Winnings

INCOME DOES NOT INCLUDE

- SNAP (Food Stamps)
- Medicaid
- Housing Assistance
- Capital Gains
- Gifts
- Loans
- Lump-Sum Inheritance
- Sale of Property
- Assets drawn down as withdrawals from a bank

Head Start/Early Head Start **Home Based** Application

Please Check: __**HS Home Based** (age 3-5) __**EHS Home Based** (age birth-2.9 yr.)

PLEASE PROVIDE YOUR CURRENT ADDRESS & PHONE NUMBERS: Date: _____

(Street &Apt. #) _____ *(Email)* _____
(City/State/Zip) _____ *(Phone #)* _____
(Your Name) _____ *(Cell #)* _____
(Relationship) _____ *(Message #)* _____

Child's Name: *(First)* _____ *(Last)* _____ Date of Birth: _____

Child's Age: _____

☐Male ☐Female

Race
☐White/Caucasian
☐Black/African American
☐Asian
☐Native Hawaiian/Pacific Islander
☐American Indian/Alaska Native
☐Hispanic (Origin) _____
☐Bi Racial (Origin) _____
☐Other_____

☐Mother ☐Father ☐Guardian ☐Foster Parent ☐Grand Parent ☐Dual Custody Family
☐Other Relationship to Child _____

Name: *(First)* _____ *(Last)* _____ Date of Birth: _____

Employment
☐Full-Time_____
☐Part-Time_____
☐School/Job Training_____
☐Unemployed/Laid off
☐Looking for employment
☐Seasonal

Education
☐>Than Grade 9
☐Grade 10
☐Grade 11
☐Grade 12
☐GED
☐High School Diploma
☐Associates Degree
☐Bachelors/Master's Degree

Race
☐White/Caucasian
☐Black/African American
☐Native Hawaiian/Pacific Islander
☐American Indian/Alaska Native
☐Asian
☐Hispanic
☐Other_____

☐Male ☐Female

Highest grade completed_____

IF ADDRESS IS DIFFERENT THAN CHILD PLEASE PROVIDE INFORMATION

Address: _____ Phone: _____

☐Mother ☐Father ☐Guardian ☐Foster Parent ☐Grand Parent ☐Dual Custody Family
☐Other Relationship to Child _____

Name: *(First)* _____ *(Last)* _____ Date of Birth: _____

Employment
☐Full-Time_____
☐Part-Time_____
☐School/Job Training_____
☐Unemployed/Laid off
☐Looking for employment
☐Seasonal

Education
☐>Than Grade 9
☐Grade 10
☐Grade 11
☐Grade 12
☐GED
☐High School Diploma
☐Associates Degree
☐Bachelors/Master's Degree

Race
☐White/Caucasian
☐Black/African American
☐Native Hawaiian/Pacific Islander
☐American Indian/Alaska Native
☐Asian
☐Hispanic
☐Other_____

☐Male ☐Female

Highest grade completed_____

IF ADDRESS IS DIFFERENT THAN CHILD PLEASE PROVIDE INFORMATION

Address: _____ Phone: _____

Additional Family Members: Please provide information for anyone living in the household *[use additional paper if necessary]*

☐Mother ☐Father ☐Other Adult ☐Child
☐ Relationship to Child ________________________________

Name: *(First)* __________________ *(Last)* ____________________ Date of Birth: ________________

Employment	Education	Race
☐Full-Time____________	☐>Than Grade 9	☐White/Caucasian
☐Part-Time____________	☐Grade 10	☐Black/African American
☐School/Job Training_______	☐Grade 11	☐Native Hawaiian/Pacific Islander
☐Unemployed/Laid off	☐Grade 12	☐American Indian/Alaska Native
☐Looking for employment	☐GED	☐Asian
☐Seasonal	☐High School Diploma	☐Hispanic
	☐Associates Degree	☐Other______________
☐Male ☐Female	☐Bachelors/Master's Degree	

Highest grade completed_____

☐Other Adult ☐Child ☐ Relationship to Child ________________________________

Name: *(First)* __________________ *(Last)* ____________________ Date of Birth: ________________

Employment	Education	Race
☐Full-Time____________	☐>Than Grade 9	☐White/Caucasian
☐Part-Time____________	☐Grade 10	☐Black/African American
☐School/Job Training_______	☐Grade 11	☐Native Hawaiian/Pacific Islander
☐Unemployed/Laid off	☐Grade 12	☐American Indian/Alaska Native
☐Looking for employment	☐GED	☐Asian
☐Seasonal	☐High School Diploma	☐Hispanic
	☐Associates Degree	☐Other______________
☐Male ☐Female	☐Bachelors/Master's Degree	

Highest grade completed_____

☐Other Adult ☐Child ☐ Relationship to Child ________________________________

Name: *(First)* __________________ *(Last)* ____________________ Date of Birth: ________________

Employment	Education	Race
☐Full-Time____________	☐>Than Grade 9	☐White/Caucasian
☐Part-Time____________	☐Grade 10	☐Black/African American
☐School/Job Training_______	☐Grade 11	☐Native Hawaiian/Pacific Islander
☐Unemployed/Laid off	☐Grade 12	☐American Indian/Alaska Native
☐Looking for employment	☐GED	☐Asian
☐Seasonal	☐High School Diploma	☐Hispanic
	☐Associates Degree	☐Other______________
☐Male ☐Female	☐Bachelors/Master's Degree	

Highest grade completed_____

☐Other Adult ☐Child ☐ Relationship to Child ________________________________

Name: *(First)* __________________ *(Last)* ____________________ Date of Birth: ________________

Employment	Education	Race
☐Full-Time____________	☐>Than Grade 9	☐White/Caucasian
☐Part-Time____________	☐Grade 10	☐Black/African American
☐School/Job Training_______	☐Grade 11	☐Native Hawaiian/Pacific Islander
☐Unemployed/Laid off	☐Grade 12	☐American Indian/Alaska Native
☐Looking for employment	☐GED	☐Asian
☐Seasonal	☐High School Diploma	☐Hispanic
	☐Associates Degree	☐Other______________
☐Male ☐Female	☐Bachelors/Master's Degree	

Highest grade completed_____

Family Size:

_____ # in the family

_____ # of children

_____ # of children 0 – 3

_____ # of children 4 – 5

_____ # of Adults & children living in the household

Services my family receives:

☐ TANF/Cash Assistance ☐ Food Stamps

☐ Unemployment Benefits ☐ SSI

☐ WIC ☐ SSD

☐ Day Care Subsides Other_____

☐ Foster Care Subsides

Family Type:

☐Two Parent/Guardian
☐ Single Female/Parent
☐ Single Male/Parent
☐ Dual Custody Family

How did you hear about the Head Start Program?

☐ Facebook ☐ flyer ☐ friend ☐ other_____

Have you applied to EOP or Head Start before? ☐ Yes ☐ No

If Yes, name of program: _____

Would you like to be contacted with information about any other programs? (Check all that apply)

☐ Medicaid ☐ WIC ☐ EDCC ☐ TANF ☐ Child Health/Family plus
☐ COE/New Day ☐ Literacy Zone ☐ Career Center ☐ SSI/SSD
☐ OPWDD ☐ Literacy Volunteers ☐ Weatherization ☐ Food Stamps

I give permission for the Enrollment Facilitator to make referrals and share information for the program that I have requested. _____ [Please initial]

Insurance: (please make sure all information is filled out)

Does your child have Health Insurance? ☐Yes ☐No Dental Insurance? ☐Yes ☐No

Physician's name _____ Dentist's name _____

☐ Medicaid # _____ Sequence # _____ (# that starts and ends with a letter)

☐ Private Insurance carrier _____ Dental Insurance carrier _____

Housing Information:

Our home type is: ☐ Rent ☐ Subsidized rent ☐ Own

My family receives: ☐ Section 8 ☐ Live in public housing

My family is temporarily living with a friend or family member because we cannot find affordable housing: ☐ Yes ☐ No

If Yes, who do you live with? _____

My family is living in emergency/transitional housing: ☐Yes ☐No

My family is living in a motel/hotel, street, camp ground or vehicle: ☐Yes ☐No

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Do you have any concerns regarding your child's development? ☐ Yes _____ ☐ No

Does your child receive speech, SEIT, PT, or OT services? ☐ Yes _____ ☐ No

Does your child have any medical or health concerns? ☐ Yes _____ ☐ No

My child will need special accommodations_____

Does your child have any food allergies? ☐ Yes _____ ☐ No (We will need a medical statement from the doctor)

Will you need an EPI Pen? ☐ Yes ☐ No (We will need a medical statement from the doctor)

Is your child fully potty trained? ☐ Yes ☐ No

Has your child been in preschool or daycare before? ☐ Yes ☐ No

Currently, during the daytime where does your child stay? _____

Is your family working with any other agencies? ☐ Yes _____ ☐ No

Primary Language _____ Secondary Language _____

Are you interested in becoming a Policy Council Member or Classroom Volunteer? _____

I have read and reviewed all the information contained within this application and the answers are complete to the best of my knowledge and belief. I understand that if any information contained within this application changes, I am obligated to notify EOP Head Start immediately. I understand that this information will be kept confidential within EOP.

☐ I give permission for Head Start to share information after completing or leaving the program for up to one year with my child's home school district for the purpose of transitional planning following enrollment in a Pre-K or Kindergarten setting.

Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

My child will be attending _____ School District.

Thank You for applying to the Head Start program. Your application will not be complete without all the necessary documentation, including the medical statement and the shot records. We will notify you as soon as placement is available for your child.

Comments:

_____

_____

_____

_____

_____

_____

Selection Criteria Sheet

Please check all that apply to your child and family:

Age:

☐ 1 month-18 Months (Early Head Start)
☐ 18 months-2 years 11 months (Early Head Start)
☐ 3 years old before Dec. 1st
☐ 3 years old after Dec. 1st
☐ 4 years old before Dec. 1st

Disabilities:

☐ Child has a disability (required documentation)
☐ Child was declassified as disabled (required documentation)
☐ Child was referred from Early Intervention/CPSE program/Other
☐ Child was referred but not classified
☐ Special Needs (Health/Nutrition)

Other Factors: (please check all that applies to your family)

☐ Unreliable vehicle or Lack of transportation
☐ Unemployment or Underemployment
☐ Housing does not meet family's needs
☐ Limited child care options/Subsidy eligible
☐ Parent in the military (past/present)
☐ Teen parent (1st child was born before the age of 21)
☐ Referral from another agency (requires documentation)
☐ Change in family dynamics (divorce, loss, grief, or marital stress)
☐ Chronically ill family member (mental, emotional, physical, or addition)
☐ Domestic violence or child abuse concerns with a family member or child
☐ Three or more children under 5 years old
☐ Incarcerated parent
☐ Previous sibling in program
☐ Unavailability of Pre-K
☐ Parent with a disability
☐ Parent attending school or job training

☐ Four or more other factors
☐ Three other factors
☐ Two other factors
☐ One other factor
☐ No apparent other factors

Parent/Guardian:

☐ Foster parent
☐ Guardian/Grandparent/Other relative
☐ Teen Parent
☐ Single parent ☐Female ☐Male
☐Two parent ☐Dual Custody

For Office Use Only

Eligible

☐ Child is in Foster Care
☐ Family is homeless/Housing is inadequate for family's need
☐ Family receives TANF (cash assistance) or SSI
☐ Income within current Poverty Guidelines

Income:

☐ Income within current Poverty Guidelines
☐ Between 100% up to 110% over poverty guidelines
☐ Between 110% up to 120% over poverty guidelines
☐ Between 120% up to 130% over poverty guidelines
☐ Between 130% up to 140% over poverty guidelines
☐ Between 140% up to 150% over poverty guidelines
☐ Over 150% poverty guidelines

Points _____

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OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date

Economic Opportunity Program, Inc.
Strengthening the fabric of our community

Main Office:
650 Baldwin Street
Elmira, NY 14901
Phone (607) 734-6174
Fax (607) 733-8126

Schuyler County Office:
112 6th Street
Watkins Glen, NY 14891
Phone (607) 535-2468
Fax (607) 535-9859

www.cseop.org
www.facebook.com/EconomicOpportunityProgram

Services

Birth to Five School Readiness Program

Center of Excellence (New Day Program)

Community Food for Jobs Program & Bistro

Energy Services Bureau

Ernie Davis Community Center

Family Support Services

Literacy Volunteers of Chemung & Schuyler Counties

EOP Birth to Five School Readiness Program
Consent for Release of Information

Child's Name: _____

Child's Date of Birth: _____

I hereby authorize EOP Birth to Five School Readiness Program to obtain or release information to the following providers:

___ Child's Local School District/Early Intervention
___ CIDS
___ DSS
___ Chemung County Public Health
___ Child's Medical Provider(s):

_____

_____

___ Other Agencies:

_____

_____

This authorization is valid for the entire 20___/20____ school year.

_____ _____
Parent/Guardian Signature Date