

EOP BIRTH TO 5 SCHOOL READINESS PROGRAM
CENTER BASED
APPLICATION

- Items needed for Completion of Application:
- Complete all sections of this application
- Proof of Current Address
- Copy of Child's Birth Certificate
- Copy of Child's Medical Insurance Card
- Signed Medical Release Form Provided In The Application
- Current Physical and Immunization records on NYS daycare form(last page of this application - for Dr to complete)
- Custody Papers (if applicable)
- **Verification of Eligibility:**
 - **Current SNAP, SSI, or TANF eligibility documentation**
 - **NOTE:** If one of the above are submitted, no other other forms of income are necessary to confirm eligibility.
 - **IF you do not have any of the above, please provide any of the following that apply:**
 - Last year's Tax Returns, W2's or 12 months of Pay Stubs
 - Any other type of income
 - See Next page if you have questions

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

Manager of Enrollment Services
650 Baldwin Street
Elmira, NY 14901
Fax: (607) 737-7210

Please call with any questions:
Ask for an Enrollment Specialist
(607) 734-6208

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Family Size:

Services my family receives:

Number in the family _____	TANF/ Cash Assistance	SNAP
Number of children _____	Unemployment Benefits	SSI
Number of children 0 - 3 _____	WIC	SSD
Number of children 4- 5 _____	Day Care Subsidies	Other _____
Number of Adults & children living in the household _____	Foster Care Subsidies	

Family Type:

How did you hear about the Birth to Five School Readiness Program?

Two Parent Facebook Flyer Friend Other _____

Single Parent/Female Have you applied to the B25 School Readiness program or another EOP program before?

Single Parent/Male Yes No

Guardian/Foster If Yes, name of program: _____

Duel Custody Family

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	SNAP	

I give permission for the Enrollment Facilitator to make referrals and share information for the programs that I have requested.

_____ (Please sign)

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 Name: _____

Medicaid #: _____ Sequence #: _____ (number 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

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

Will you need an EPI pen? Yes No (We will need a medical statement from your doctor)

Is your child fully potty trained? Yes No

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

Currently where is your child staying during the daytime? _____

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

Primary Language: _____ Secondary Language: _____

Does your family have reliable transportation? Yes No

Head Start only: If available, do you need busing? (EDFC and Able 2 only) Yes No

Are you interested in becoming a Policy Council Member or Classroom Volunteer? Yes No

Policy Council 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 obliged 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 the: _____ 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.

I am interested in the following site locations (Placement will depend on availability of slots):

Able2 A'Don Allen BOCES Broad Street EDFC Libertad Any Site

Comments:



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

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

Services

Birth to Five School
Readiness Program

Center of Excellence
(New Day Program)

Community Food For Jobs
Programs & Bistro

Energy Services Bureau

Ernie Davis Community
Center

Family Support Services

Literacy Volunteers of
Chemung & Schuyler
Counties

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:

Primary Healthcare Provider

Child's Local School District/Early Intervention

CIDS

DSS

Chemung County Public Health

Other Agencies:

This authorization is valid for the entire 20 20 School year.

Parent/Guardian Signature

Date



Est. 2018

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

