

**EOP BIRTH TO 5 SCHOOL READINESS PROGRAM**  
**CENTER 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 Medical Release Form Provided In The Application
- Completed Medical Statement (current physical and immunization records)
- Custody Papers (if applicable)
- **Verification of Income:**
  - **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**

As Part of the application process, the Head Start and Early Head Start Center 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:

- **SNAP (Food Stamps), SSI, or TANF**
  - **NOTE:** If one of the above are submitted, no other other forms of income are necessary to confirm eligibility.
- 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
- 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:

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





**Family Size:**

**Services my family receives:**

|  |                       |             |
|--|-----------------------|-------------|
| Number in the family<br>_____                                | TANF/ Cash Assistance | SNAP        |
| Number of children<br>_____                                  | Unemployment Benefits | SSI         |
| Number of children 0 - 3<br>_____                            | WIC                   | SSD         |
| Number of children 4- 5<br>_____                             | Day Care Subsidies    | Other _____ |
| Number of Adults & children living in the household<br>_____ | 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 Broad Street EDFC Libertad Any Site

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Please check all that apply to your child and family:***

**Age:**

- 18 months - 2 years 11 months (*Early Head Start*)
- 3 years old before December 1st
- 3 years old after December 1st
- 4 years old before December 1st

**Disabilities:**

- Child has a disability (*required documentation*)
  - Only when disability percentage in program is less than 10% enrolled***
- Child was declassified as disabled (*required documentation*)
- Child was referred from Early Intervention/CSPE 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 addiction*)
- Domestic violence or child abuse concerns with a family member or child
  - Four or more other factors
  - Three other factors
  - Two other factors
  - One other factor
  - No apparent other factors

- 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
- Family seriously effected by COVID-19
- How? \_\_\_\_\_

**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 needs
- Family receives Public Assistance (TANF, SSI or SNAP)
- Income within current Poverty Guidelines

**Income:**

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

***Total Points***

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# 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](http://www.cseop.org)

[www.facebook.com/EconomicOpportunityProgram](https://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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**Additional Family Members:** Please provide information for anyone living in the household.

*Extra form, use if needed.*

Mother    Father    Other Adult    Child

Relationship to Child: \_\_\_\_\_

**Name:** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employment: \_\_\_\_\_

Education: \_\_\_\_\_

Race: \_\_\_\_\_

Full Time (Where?) \_\_\_\_\_

< Than Grade 9\*

White/Caucasian

Part Time (Where?) \_\_\_\_\_

Grade 10

Black/African American

School/Job Training (Where?) \_\_\_\_\_

Grade 11

Asian

Looking for Employment

Grade 12

Native Hawaiian/Pacific Islander

Unemployed/Laid Off

GED

American Indian/ Alaska Native

Seasonal

High School Diploma

Hispanic (Origin) \_\_\_\_\_

Associates Degree

Bi-Racial (Origin) \_\_\_\_\_

Bachelors/Master's Degree

Other \_\_\_\_\_

\*Highest Grade Completed: \_\_\_\_\_

Mother    Father    Other Adult    Child

Relationship to Child: \_\_\_\_\_

**Name:** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employment: \_\_\_\_\_

Education: \_\_\_\_\_

Race: \_\_\_\_\_

Full Time (Where?) \_\_\_\_\_

< Than Grade 9\*

White/Caucasian

Part Time (Where?) \_\_\_\_\_

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High School Diploma

Hispanic (Origin) \_\_\_\_\_

Associates Degree

Bi-Racial (Origin) \_\_\_\_\_

Bachelors/Master's Degree

Other \_\_\_\_\_

\*Highest Grade Completed: \_\_\_\_\_

Mother    Father    Other Adult    Child

Relationship to Child: \_\_\_\_\_

**Name:** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employment: \_\_\_\_\_

Education: \_\_\_\_\_

Race: \_\_\_\_\_

Full Time (Where?) \_\_\_\_\_

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Associates Degree

Bi-Racial (Origin) \_\_\_\_\_

Bachelors/Master's Degree

Other \_\_\_\_\_

\*Highest Grade Completed: \_\_\_\_\_