Berne Knox Westerlo School District
Universal Prekindergarten Program
2018-2019 School Year

1738 Helderberg Trail Berne, NY 12023
Phone: (518) 872-2030 Fax: (518) 872-2031

Universal Pre-K Program Information:

You must make an appointment to register for the UPK Program.
Please call **872-2030** to schedule your registration time.
Registration will be held March 21st, 22nd, 23rd at the elementary school.

PLEASE BRING THE FOLLOWING ITEMS TO YOUR REGISTRATION APPOINTMENT. *YOUR APPLICATION CANNOT BE PROCESSED WITHOUT **ALL** OF THE FOLLOWING:*

1. Completed Application

2. Proof of Residency- *(any of the following)*
- **Acceptable** proof of residence:
  - Mortgage or property tax statement
  - Certificate of Occupancy
  - Utility Bill
  -Tax Bill

3. Child's Birth Certificate
- Children must be age 4 by December 1st to attend the Pre-K Program.

4. Parent's ID

5. Child's Medicaid or Health Insurance Card

6. Child's Immunization Record
- A current physical is required prior to your child starting (within one year)

7. Proof of Income for everyone in the household
- P.A. Budget Sheet; W-2 Form (prior year); Four weeks' worth of employment pay stubs or Unemployment Receipts, Child Support Payments, SSI Documentation, etc.

8. Custody Paperwork, *if applicable*

UPK placements are limited and will be assigned through a selection process. Applications not initially selected will be placed on a waiting list and called when a space becomes available.

SELECTION WILL BE ON APRIL 13th. IF YOUR APPLICATION IS CHOOSEN YOU WILL RECEIVE AN ACCEPTANCE LETTER BY MID April

The UPK program Morning session operates from 7:45am – 11:30. The afternoon session operates from 11:00am-2:45pm. Both session follow the BKW calendar and only lunch is offered in the cafeteria.

Student Number _____

STUDENT NAME: _____ **EXPECTED ENROLLMENT DATE:** _____

GRADE LEVEL: _____ **DATE OF BIRTH:** _____

Residential Address: _____
House # Street Apt #

_____
City State Zip

Mailing Address: (if different from above) _____

_____

Household Phone Number – To be designated for emergency school notifications (i.e. school closings): _____

Is English the only language spoken at home? Yes _____ No _____

If no, what other language does your family speak? _____ Is your child bilingual? Yes _____ No _____

Student Racial and Ethnic Identification as specified by the NYS Dept. of Education

Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. _____ Yes, Hispanic _____ No, not Hispanic

Select one or more races from the following five racial groups:

O AMERICAN INDIAN or ALASKA NATIVE: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.(e.g. Cherokee, Mohawk, Inuit.)

O ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

O NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

O BLACK: A person having origins in any of the black racial groups of Africa

O WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Child's Place of Birth: City: _____ State: _____

Was your child born **outside the United States?** No _____ Yes_____ **If Yes, please answer questions below:**

What country was your child born in? _____ Date of entry into the United States: _____

Date child first entered U.S. schools:_____ Date child first entered NY schools: _____

Did your child previously attend the BKW Central School? Yes __ No ____ Date Left _____

ALL CHILDREN LIVING IN PRIMARY HOUSEHOLD UNDER THE AGE OF 21

Last Name	First Name	Middle	SEX M/F	Date of Birth	Grade	Birth Cert. Received	Student ID# Office Use Only

PRIMARY HOUSEHOLD PARENT / GUARDIAN INFORMATION

(Only list those adults currently living in the household)

Father / Male Guardian / Other Adult Male: _____

Living in the household with the child listed above — *Last Name* — *First Name* — *Middle Name*

Relationship to child(ren) _____

Work Number:_____ Cell Phone Number: _____ Other Number: _____

Email Address:_____ Occupation: _____

Mother / Female Guardian / Other Adult Female: _____

Living in the household with the child listed above — *Last Name* — *First Name* — *Middle Name*

Relationship to child(ren) _____

Work Number:_____ Cell Phone Number: _____ Pager Number: _____

Email Address:_____ Occupation: _____

NON-HOUSEHOLD PARENT: If dad or mom is not residing in the primary household, please list their information below.

_____

Last Name — *First Name* — *Middle Name*

Relationship to child(ren) listed above _____

Home Address: _____

Work Number:_____ Cell Phone Number: _____ Other Number: _____

Email Address:_____ Occupation: _____

Any legal custodial restrictions? No_____ Yes_____ **If yes, please attach court documents.**

Important Note Regarding Release of Students from School: *The school district shall presume that either parent of a student has authority to obtain the child's release from school. However, a student shall not be released to a non-custodial parent if the district has been provided with a certified copy of a legally binding instrument, such as a court order or decree of divorce, separation or custody, that indicates the non-custodial parent does not have the right to obtain such release.*

Is **BKW CSD** **currently** transporting your child to private school? No _____ Yes _____

If **Yes**, please cancel my application for non-public transportation as of_____(date):

Parent Signature: _____ Date: _____

Special Education Needs:

Is your child **CURRENTLY** **receiving special education services?** No _____ Yes _____

If Yes, please place a checkmark next to each service he/she is receiving.

_____Speech / Language Therapy	_____Occupational Therapy	_____Physical Therapy
_____Consultant Teacher	_____Self-Contained Classroom	_____Resource Room
_____BOCES	_____504 Plan	_____Declassified
_____1:1 Aide	_____ Classroom Aide	_____Extended Test Taking Time

Other Special Education Needs:

_____

Has your child ever received special education services **IN THE PAST?** No _____ Yes _____

Services Received: _____

Date Services Ended: _____

Names, addresses and phone numbers of two people with whom you have made arrangements to take responsibility for your child in the event you cannot be reached.

Emergency Contact #1	_____	Emergency Contact #2	_____
Gender	_____	Gender	_____
Relationship to Student	_____	Relationship to Student	_____
Street Address	_____	Street Address	_____
City, State, Zip	_____	City, State, Zip	_____
Home Phone	_____	Home Phone	_____
Work Phone	_____	Work Phone	_____
Cell Phone	_____	Cell Phone	_____

Parent Statement:

I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Berne-Knox-Westerlo Central School District.

Parent
Signature: _____ Date: _____

The student information we enter and maintain in BKW's electronic Student Information System is used for many purposes. Please be aware that when an adult who is not a parent or legal guardian resides with a student's family, and is included in the student's permanent record, it is assumed we have the parent's permission to discuss academic, disciplinary and other student matters with that adult. In addition, "other adult in household" may be contacted in emergencies. Therefore non-parent/legal guardian adults should not be included on the registration form unless you agree with the above and sign the statement below.
Our schools maintain separate Emergency Contact information and you may indicate any adult of your choosing to be contacted should an emergency occur and you cannot be reached.
When/if any of the information you are providing changes, please inform your child's school in order to ensure we have the most up-to-date information on file.
By signing below, you are agreeing that the non-parent/legal guardian may be contacted regarding your child.

Parent
Signature: _____ Date: _____

Print Name Here:_____Relationship to Student: _____

Berne-Knox-Westerlo Central School District

Student Residency Questionnaire

Name of School: _____ Grade: _____

Name of Student: _____ Sex: _____ Male
Last First Middle _____ Female

Birth Date: ___/___/___ Age: _____ Student ID # _____
Month / Day / Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? _____ Yes _____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?
_____ Yes _____ No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living? (Check one)

_____ In a motel
_____ In a shelter
_____ With more than one family in a house or apartment
_____ Moving from place to place
_____ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardians(s) _____

Address_____ Zip _____ Phone(s) _____

** Is transportation (bus) required: _____ Yes _____ No
** If "Yes," What date would you like transportation to start ? _____
(We will make every effort to accommodate your request).

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian _____ Date_____
Signature of School Official _____ Date_____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date _____ ***McKinney-Vento Liaison Signature*** _____

HEALTH FORM
BERNE-KNOX-WESTERLO CENTRAL SCHOOL
(to be completed by parent)

Date_____

Name_____ Sex _____

Date and Place of Birth_____ Grade _____

Parent/s or Guardian (resides with)_____

Address_____

Father's Name_____ Home Phone _____

Mother's Name_____ Home Phone _____

Father's Place of Business_____ Phone_____

Mother's Place of Business_____ Phone_____

Family Physician_____ Phone_____

Has your child ever had any of the following? If so, indicate the date.

Chicken Pox_____	Pneumonia_____	Diabetes_____
Diphtheria_____	Poliomyelitis_____	Seizures_____
German Measles_____	Rheumatic Fever_____	Heart Disease_____
Mumps_____	Scarlet Fever_____	Tuberculosis_____
Measles_____	Whooping Cough_____	Contact with TB_____

CHECK IF HISTORY AND DESCRIBE **Please list dates, type and medications.**

Asthma	Frequent colds & sore throat
Bee Sting Allergy	Ear condition
Allergies	Frequent Headaches
Operations	Serious injuries

Under treatment at this time for any other condition?_____

Revised 1/13/06

IMMUNIZATIONS
(Please attach physician's record or physician may complete this form)

IPV _____ _____ _____ _____

DTaP _____ _____ _____ _____ _____ Tdap _____

HIB _____ _____ _____ _____

Hep B _____ _____ _____

Prevnar _____ _____ _____ _____

MMR _____ _____

Varivax _____ _____

Hep A _____ _____

Menactra _____

Gardasil _____ _____ _____

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Berne-Knox-Westerlo CSD

STUDENT HEALTH EXAMINATION FORM (To be completed by private health care provider or school medical director)

Note: NYSED requires a physical exam for new entrants and students in Grades pre-K or K, 2, 4, 7 & 10, interscholastic sports and working papers.

Name: _____ DOB: _____ Gender: ☐M ☐F

School: Grade: ☐No Grade Exam Date:

IMMUNIZATIONS

☐ Immunization record attached

☐ Immunizations reported on NYSIIS

☐ No immunizations received today

☐Immunizations received today:

☐Will return on: to receive:

HEALTH HISTORY

☐**Asthma:** ☐Intermittent ☐Persistent ☐Asthma Action Plan Attached

☐**Diabetes:** ☐Type I ☐ Type 2 ☐Hyperlipidemia ☐Hypertension ☐Diabetes Medical Mgmt Plan Attached

☐**Seizures** Type: _____ Last Occurrence: _____ ☐Emergency Care Plan Attached

☐**Allergies:** ☐Non Life-Threatening ☐Life-Threatening ☐Emergency Care Plan Attached

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Allergen(s):

☐Hx of Anaphylaxis: Last occurrence: _____ Previous symptoms: _____

Treatment prescribed: ☐None ☐Antihistimine ☐Epinephrine Autoinjector

Significant Medical/Surgical Information:	Diagnostic Tests	Positive	Negative	Not Done	Date
	Sickle Cell Screen	☐	☐	☐	
	PPD	☐	☐	☐	
	Elevated Lead:	☐	☐	☐	

☐Vision one eye only ☐One functioning kidney ☐One testicle ☐Concussion - Last occurrence:

PHYSICAL EXAMINATION

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Scoliosis: ☐Negative ☐Positive

Degree of deviation: _____

Angle of trunk rotation via scoliometer:

Weight Status Category (BMI Percentile):

☐ <5th ☐ 85th - 94th

☐ 5th - 49th ☐ 95th - 98th

☐ 50th - 84th ☐ 99th & higher

Vision	Right	Left	*Referral*
Distance acuity			☐Yes ☐No
Distance acuity with lenses			☐Yes ☐No
Vision - near vision			☐Yes ☐No
Vision - color perception	☐ Pass	☐ Fail	☐Yes ☐No
Hearing	**Right**	**Left**	***Referral***
☐ 20 db sweep screen both ears or			☐Yes ☐No

Check developmental stage (ONLY for Athletic Placement Process for 7th & 8th graders): Tanner: ☐I ☐II ☐III ☐IV ☐V

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL ☐ Additional information attached

Specify any abnormalities:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

- ☐ **No Contact Sports** includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, track & field, fencing, badminton
- ☐ **Other Specific Restrictions:**

Accommodations / Protective Equipment:	☐Athletic Cup	☐Insulin Pump/Insulin Sensor	☐Pacemaker
	☐Brace/Orthotic	☐Medical /Prosthetic Device	☐Sports Safety Goggles
	☐Hearing Aides	☐Other:	

MEDICATION HISTORY (optional)

Please list names of prescribed or OTC medications used on a routine basis at home

_____ _____

_____ _____

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine autoinjector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

☐ **Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child

Parent/Guardian Signature:

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: _____ Date: _____

Provider Name: (please print) _____ Phone #: ( )

Provider Address: _____ Fax #: ( )

Return to:

School Nurse: Katie Johnson School: B-K-W

Phone #: (518) 872-2030 Fax: (518) 872-2031 Date:

albany community action partnership
THE POWER OF CHANGE

333 Sheridan Avenue, Albany, NY 12206
Tel. 518-463-3175 Fax 518-463-8185
www.albanycap.org

Customer Intake Application

How did you hear about us? _____

What brings you to ACAP today? ☐ Employment ☐ Weatherization ☐ Income Tax Prep ☐ Head Start ☐ Food Pantry ☐ Child Care ☐ Dress For Success ☐ Early Start ☐ Money Follows People ☐ Other Help

First Name	Last Name	Middle Initial	Gender ☐Male ☐Female	Birth Date / /

Are you the Head of Household? ☐ Yes ☐ No	Social Security Number	Place of Birth

Physical Address	City	State	Zip

Mailing Address if different from above	City	State	Zip

Home Phone	Cell Phone	May we contact you via text message? ☐YES ☐NO	Work Phone

County of Residence	Email

How many people are in your household?
Number of adults _____
Number of children _____
Number of parents (of minors) _____
Total Family size _____

Family Type: ☐ Male/Female single parent ☐ Single adult ☐ Adults w/ child(ren) ☐ Adults w/ no child(ren) ☐ Other: _____

Citizenship status: ☐ Citizen ☐ Permanent Legal Resident ☐ Alien authorized to work ☐ Other: _____

What type of housing do you live in?
☐Apartment ☐House ☐ Share Housing ☐Shelter ☐Hotel/Motel ☐ No Housing/Homeless

Do you:
☐ Rent ☐ Receive subsidized housing ☐ Own ☐ Do not pay for housing ☐ Other: Please Specify: _____

Do you consider your housing to be adequate? ☐Yes ☐No

What is your family's primary mode of transportation?
☐Private Car ☐Public Transportation ☐Friend's/Relative's Car ☐ Other Please Specify: _____

☐Yes ☐No	Are you a recent Refugee family? If YES, Please specify the agencies you work with:	
☐Yes ☐No	Is anyone in your household currently receiving Food Stamps / SNAP? If YES, Please specify who: _____	
☐Yes ☐No	Is anyone in your household currently receiving WIC? If YES, Please specify who: _____	
☐Yes ☐No	Is anyone in your household currently deployed on military duty? If YES, Please specify who: _____	
☐Yes ☐No	Have any of your children attended Head Start previously? If YES, Please specify where: _____	
☐Yes ☐No	Do you receive a child care subsidy? If YES, where does it come from (DSS, WDI, etc...)? _____	
☐Yes ☐No	Is anyone in your household pregnant? If YES, Please specify who: _____	What is her due date? _____
☐Yes ☐No	Is anyone in your household disabled? If YES, Please specify who: _____	Please specify: _____

Please list any other concerns you may have for your child(ren) or family:

List below information on <u>all</u> members of the household

First and Last Name	Relationship to Head of Household	Date of Birth	Social Security Number	Does this person have Medical insurance?	Education level	Gender	Ethnicity: Hispanic or Latino Origin?	Race	Language	Marital status
	Self			☐Yes ☐No	☐ Non-grad. Yr left___ ____ ☐ HS Grad/GED ☐ 2 yr college degree ☐ 4 yr college degree ☐ Graduate degree	☐Male ☐Female	☐Yes ☐No	☐ Amer Indian/ Alaska Native ☐ Asian ☐ Black/ African Amer ☐ White ☐ 2 or more races ☐ Other ____________		☐Never Married ☐Married ☐Separated ☐ Divorced ☐Widowed
				☐Yes ☐No	☐ Non-grad. Yr left___ ____ ☐ HS Grad/GED ☐ 2 yr college degree ☐ 4 yr college degree ☐ Graduate degree	☐Male ☐Female	☐Yes ☐No	☐ Amer Indian/ Alaska Native ☐ Asian ☐ Black/ African Amer ☐ White ☐ 2 or more races ☐ Other ____________		☐Never Married ☐Married ☐Separated ☐ Divorced ☐Widowed
				☐Yes ☐No	☐ Non-grad. Yr left___ ____ ☐ HS Grad/GED ☐ 2 yr college degree ☐ 4 yr college degree ☐ Graduate degree	☐Male ☐Female	☐Yes ☐No	☐ Amer Indian/ Alaska Native ☐ Asian ☐ Black/ African Amer ☐ White ☐ 2 or more races ☐ Other ____________		☐Never Married ☐Married ☐Separated ☐ Divorced ☐Widowed
				☐Yes ☐No	☐ Non-grad. Yr left___ ____ ☐ HS Grad/GED ☐ 2 yr college degree ☐ 4 yr college degree ☐ Graduate degree	☐Male ☐Female	☐Yes ☐No	☐ Amer Indian/ Alaska Native ☐ Asian ☐ Black/ African Amer ☐ White ☐ 2 or more races ☐ Other ____________		☐Never Married ☐Married ☐Separated ☐ Divorced ☐Widowed
				☐Yes ☐No	☐ Non-grad. Yr left___ ____ ☐ HS Grad/GED ☐ 2 yr college degree ☐ 4 yr college degree ☐ Graduate degree	☐Male ☐Female	☐Yes ☐No	☐ Amer Indian/ Alaska Native ☐ Asian ☐ Black/ African Amer ☐ White ☐ 2 or more races ☐ Other ____________		☐Never Married ☐Married ☐Separated ☐ Divorced ☐Widowed
				☐Yes ☐No	☐ Non-grad. Yr left___ ____ ☐ HS Grad/GED ☐ 2 yr college degree ☐ 4 yr college degree ☐ Graduate degree	☐Male ☐Female	☐Yes ☐No	☐ Amer Indian/ Alaska Native ☐ Asian ☐ Black/ African Amer ☐ White ☐ 2 or more races ☐ Other ____________		☐Never Married ☐Married ☐Separated ☐ Divorced ☐Widowed

*List below income sources and amounts for **all** adults in the household.*				
First and Last Name	Income Sources	Pay Frequency	Employment status	Is this person able to work?
	☐ Public Assistance / TANF ☐ Supplemental Social Security Income (SSI) ☐ Unemployment Compensation ☐ Social Security Survivor's Benefits ☐ Military Family Allotments ☐ Social Security Disability ☐ Retirement / Pension ☐ Wages ☐ Rental Properties ☐ Social Security ☐ Veteran's Benefits ☐ Child Support ☐ Alimony ☐ Other: ______		☐Full-time ☐Part-time ☐ Self-employed ☐Unemployed ☐Seeking work ☐Retired ☐Other: ______	☐Yes ☐No
	☐ Public Assistance / TANF ☐ Supplemental Social Security Income (SSI) ☐ Unemployment Compensation ☐ Social Security Survivor's Benefits ☐ Military Family Allotments ☐ Social Security Disability ☐ Retirement / Pension ☐ Wages ☐ Rental Properties ☐ Social Security ☐ Veteran's Benefits ☐ Child Support ☐ Alimony ☐ Other: ______		☐Full-time ☐Part-time ☐ Self-employed ☐Unemployed ☐Seeking work ☐Retired ☐Other: ______	☐Yes ☐No
	☐ Public Assistance / TANF ☐ Supplemental Social Security Income (SSI) ☐ Unemployment Compensation ☐ Social Security Survivor's Benefits ☐ Military Family Allotments ☐ Social Security Disability ☐ Retirement / Pension ☐ Wages ☐ Rental Properties ☐ Social Security ☐ Veteran's Benefits ☐ Child Support ☐ Alimony ☐ Other: ______		☐Full-time ☐Part-time ☐ Self-employed ☐Unemployed ☐Seeking work ☐Retired ☐Other: ______	☐Yes ☐No
	☐ Public Assistance / TANF ☐ Supplemental Social Security Income (SSI) ☐ Unemployment Compensation ☐ Social Security Survivor's Benefits ☐ Military Family Allotments ☐ Social Security Disability ☐ Retirement / Pension ☐ Wages ☐ Rental Properties ☐ Social Security ☐ Veteran's Benefits ☐ Child Support ☐ Alimony ☐ Other: ______		☐Full-time ☐Part-time ☐ Self-employed ☐Unemployed ☐Seeking work ☐Retired ☐Other: ______	☐Yes ☐No

ACAP is committed to providing quality services to our customers. In order to effectively render quality service and better serve our customers, it is necessary to obtain some confidential personal information. This level of service necessitates that information obtained by ACAP be shared with other agency program personnel to the extent that it benefits you and your family. It may also necessitate sharing of information with external referral agencies to aide them in assisting you and/or your family members, without your having to provide that same information again. ACAP recognizes that a strong sense of trust must be established between the agency and our customers: personal records and information held by our programs, and shared with permissible outside agencies, will be maintained with the strictest degree of confidence, **by all.**

My signature verifies that I have willingly agreed to provide the information requested and I acknowledge the information will be entered into the ACAP database to provide the best level of services that can be offered by ACAP. I also understand this information may be shared with other ACAP programs and with my permission may be sent to external referral agencies on my behalf to aide me in achieving my goals.

Applicant Signature ______________________ Date ______________

Albany Community Action Partnership and its programs do not permit discrimination on the basis of color, race, sex, disability, religion, or national origin.

Office Use Only:

Date Application received: ______________

Received by: ______________

Entry date: ________ Staff Initials: ______