

Preschool Application

For the 2021-2022 School Year

*Revised April 2021

Dear Parents and Guardians,

In order for your child to be considered for the **lottery to determine acceptance** into the Bedford City Schools Preschool Program, you must complete and return these items to:

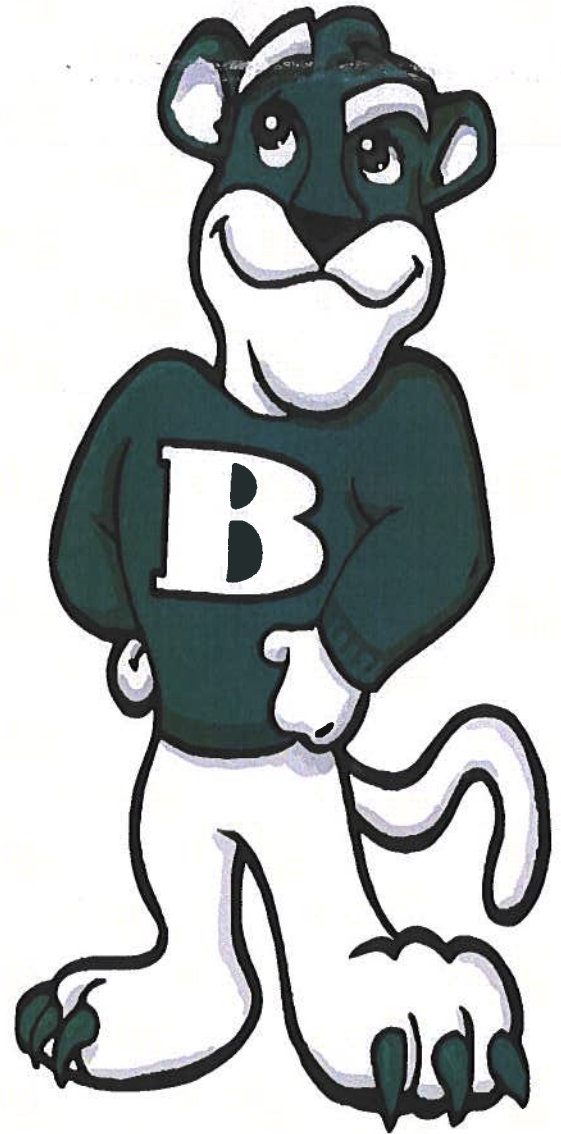
Administration Center

475 Northfield Road

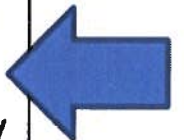
Bedford, OH 44146

- Application Form
- Health Screening Requirement Form
- Income and Residency Verification Form
- Acknowledgement of Privacy Practices
- COPA Application
- Proof of Income (provide copies)
 - W-2's for all in home
 - 1040's for all in home
 - Multiple paystubs
 - Public assistance letter(at least one of the above)

*If you have any questions about this process, please contact Diane Schentur, Director of Preschool at 440-786-3518 or dschentur@bedfordschools.org or Katy Burant-School Psychologist at 440-439-4227 x3735 or kburant@bedfordschools.org



Applications will be accepted through Friday, May 28th to be considered for the lottery. Applications received after this date will be automatically placed on a wait list, should a spot become available. At that time, a lottery will take place again for the open slot.



Bedford City Schools

Full Time Programming

Please read the following in its entirety for full understanding of program requirements

Program/Requirements:

- Full time session, Monday through Friday; start times will be communicated once the lottery takes place and the district determines your child's school placement (Glendale Primary School or Central Primary School)
 - Subject to change pending COVID regulations and restrictions.
- **Children must be four years old *on or before September 30, 2021 for the full time classroom.***
- Hours of operation are 8:30-3:00
- Morning drop off by 8:15 AM and afternoon pick up at 3:00 PM
- Compliance with preschool regulations, which include required paperwork/physicals, and conferences
- Compliance with the communicable disease policy, including requirements for immunizations and physical examination within thirty days of school entrance and annually for returning students
- Transportation will not be provided. It is the parent's responsibility to transport the child to and from school
- Children must maintain a positive attendance record
- Parents are required to drop off and pick up their children on time to avoid exclusion from the program
- Fee is 95.00 per week, which is billed monthly. Dates determined according to each school year calendar. This will be outlined once your child is accepted into the program and after registration.

Tuition reduction:

- Poverty guidelines will be utilized to determine a sliding fee schedule/reduced tuition for students.
- Verification required includes proof of household income (W2, 1040, current pay stubs or letter verifying family income or need for assistance or foster child information)
- Vouchers not accepted at this time

Application procedure:

- Complete application
- Complete UPK Health Screening acknowledgement form
- Complete Income & Residency Verification form 2021-22
- Submit W2, 1040, or current pay stubs or ECE/reduced tuition consideration
- Return application packet to the Administration Building
 - If incomplete, the application will not be accepted and returned to the family, detailing the required information that is missing
 - Families will have an opportunity to resubmit
- All applicants will be notified regarding acceptance into the programming by phone or letter
 - Directions on how to enroll/register your student will be provided upon acceptance into the program
 - Families will receive and sign a tuition payment calendar that details financial obligations and payment schedule
 - Once slots are filled, a wait list will be established and a lottery held for that open spot

Bedford City Schools

Part-Time Peer Programming

Please read the following in its entirety for full understanding of program requirements

Program:

- AM Session: TBD Monday through Friday
- PM Session: TBD Monday through Friday
- Children will be assigned to each special education integrated classroom
- Child's placement is completed by staff. Special requests cannot be considered.
- Children will meet criteria for peer models, as determined by Bedford City Schools

Participation Requirements:

- Children must be three years old on or before August 1, 2021.
- Compliance with preschool regulations, which include required paperwork/physicals, and conferences
- Compliance with the communicable disease policy, including requirements for immunizations and physical examination prior to school entrance
- **Transportation will not be provided.** It is the parent's responsibility to transport the child to and from school
- Children must maintain a positive attendance record to avoid exclusion from the program
- Parents are required to drop off and pick up their children on time
- **Fee is \$20.00 per week**, which is billed monthly. Dates determined according to each school year calendar. This will be outlined once your child is accepted into the program. Poverty guidelines will be utilized to determine a sliding fee schedule/reduced tuition for students. Vouchers are not accepted.

Application procedure:

- Complete application
- Complete UPK Health Screening acknowledgement form
- Complete Income & Residency Verification form 2021-2022
- Submit W2, 1040, or current pay stubs for reduced tuition consideration
- Return application packet to The Bedford Board of Education, 475 Northfield Road.
 - *If incomplete*, the application *will not be accepted and returned to the family*, detailing the required information that is missing
 - Families will have an opportunity to resubmit
- All applicants will be notified regarding acceptance into the programming by phone or letter
 - Directions on how to register your student will be provided upon acceptance into the program
 - Families will receive and sign a tuition payment calendar that details financial obligations and payment schedule

Bedford City School District

Application Form 2021-22

*Students must be 3 years old on or before August 1st for the part time program.

*Students must be 4 years old on or before September 30th for the full time program.

Child's Name: _____ Gender: Female or Male

Address: _____ City: _____

Date of Birth: _____

Parent or Guardian's Name: _____

Parent or Guardian's Phone Number(s): _____

Parent or Guardian's Email address: _____

*It is the family's responsibility to contact the district throughout the application period to update any changes to contact information, including a current phone number.

I am applying for: _____ Part Time Program _____ Full Time Program

If full time programs are full, is your family willing to accept a part time position ? _____ Yes _____ No

Parent or Guardian's signature: _____ Date: _____

Office use ONLY:

UPK/part	UPK/full	ECE	PL %	EMIS PL %



Universal Pre-Kindergarten Health Screening Resources

Medical Services (Immunizations, Lead Screening, Well Child Visits)

Name	Address	Phone Number	Payment Method
Cleveland Department of Public Health Services: <i>Immunizations and Lead Screening(must make apt in advance) Reproductive health screenings</i>	The City of Cleveland Health Centers: ●J. Glen Smith Health Center-11100 St. Clair Ave., Cleveland, OH 44108 ●Thomas F. McCafferty Health Center - 4242 Lorain Ave., Cleveland, OH 44113 Lead Safe Living Hotline	216-664-7095 216-664-6603 216-263-5323	Private insurance; Sliding fee scale. If no insurance, patients are referred for enrollment in Medicaid or Marketplace
Cuyahoga County Board of Health Services: <i>Immunizations and Lead Screening</i>	5550 Venture Rd., Parma, OH 44130	216-201-2041	Medicaid accepted Call for an appointment and information regarding non-Medicaid payment options (Lead screening once a month by appointment)
Northeast Ohio Neighborhood Health Services, Inc. Services: <i>Dental Immunizations Lead Screening</i> Provides all medical services (functions as a medical home)	●East Cleveland Health Center-15201 Euclid Ave., East Cleveland, OH 44112 ●Superior Health Center-12100 Superior Ave., Cleveland, OH 44106 ●Southeast Health Center-13301 Miles Ave., Cleveland, OH 44105 ●Norwood Health Center-1468 E. 55 th St., Cleveland, OH 44103 ●Hough Health Center-8300 Hough Ave., Cleveland, OH 44103 ●Collinwood Health Center-15322 St. Clair Ave., Cleveland, OH 44110 ● Miles/Broadway Health Center-9127 Miles Ave., Cleveland, OH 44105	216-541-5600 216-851-2600 216-751-3100 216-881-2000 216-231-7700 216-851-1500 216-664-6544	Medicaid; private insurance and has a discounted fee structure based on family size and income (No dental at Miles/Broadway) *Central Intake 216-231-7700, press 2 for pediatrics
Care Alliance Health Care Services: <i>Dental, Immunizations, Lead Screening</i> Provides all medical services (functions as a medical home)	●Central Neighborhood Clinic-2916 Central Ave. Cleveland, OH 44115 ●St. Clair Clinic- 1530 St. Clair Ave. Cleveland, OH 44144 ●Riverview Tower Clinic-1795 W. 25 th St., Cleveland, OH 44113 ●Carl B. Stokes Clinic- 6001 Woodland Ave., 2 nd Floor, Cleveland, OH 44104	216-535-9100 216-781-6724 216-619-5571 216-923-5000	Medicaid and Sliding scale
Circle Health Services Services: Dental, Behavioral Health, Immunizations, Lead Screening Provides all medical services (functions as a medical home)	● 12201 Euclid Ave. Cleveland, OH 44106	216-721-4010 Appointment line: 216-325-WELL	Medicaid; private insurance; and sliding fee scale



Universal Pre-Kindergarten Health Screening Resources

Pediatric Dental

Provider Name	Address	Phone Number	Payment Method
CWRU School of Dental Medicine Early Childhood Dental Program*	2124 Cornell Rd., Cleveland, OH 44106	216-368-0665	Medicaid; Private insurance needs to be paid at point of service with patient submitting to insurance
Tapper Dental Center at University Hospitals	Rainbow Babies and Children's Hospital 1100 Euclid Ave., Cleveland, OH 44106	216-844-3080	Medicaid and Private Insurance
Tri-C's Dental Hygiene Clinic <i>Preventative Treatment Only</i>	2900 Community College Ave., MetroHealth Careers and School (MHCS), Rm.127, Cleveland, OH 441155	216-987-4413 Call for an appointment	Cash or check only; No insurance accepted \$10- Children 17 yrs. and younger; \$15- ages 18 and up
MetroHealth Medical Center	<ul style="list-style-type: none"> •Main Campus- Dental Clinic, 2500 MetroHealth Dr., Cleveland, OH 44109 •Lee-Harvard Clinic- 4071 Lee Rd., Ste.260, Cleveland, OH 44128 •Old Brooklyn Campus-4229 Pearl Rd., Cleveland OH 44109 •Broadway Health Center- 6835 Broadway Ave., Cleveland, OH 44105 	216-778-4725 216-957-1222 216-957-1850 216-957-1850	Medicaid; Private insurance; Sliding fee scale
Northeast Ohio Neighborhood Health Services, Inc.	(NEON does provide pediatric dental services- details above)		
Care Alliance Health Care	(Care Alliance does provide pediatric dental services -details above)		
St. Luke's Dental Practice	1201 Shaker Blvd. Cleveland, OH 44104	216-368-7238 Call for an appointment	Medicaid; Private Insurance; Sliding fee scale

Hearing, Speech & Vision

Name	Address	Phone Number	Payment Method
Cleveland Hearing & Speech Center	<ul style="list-style-type: none"> •11635 Euclid Ave., Cleveland, OH 44106 •4257 Mayfield Rd., S. Euclid, OH 44121 •7000 Town Dr.#200, Broadview Hts., OH 44147 •29540 Center Ridge Rd., Westlake, OH 44145 	216-231-8787 216-382-4520 440-838-1477 440-455-9898	Medicaid; Private Insurance; Sliding fee scale
Prevent Blindness Ohio-Northeast OH Chapter* (trains providers on how to screen)	Hillcrest Medical Building#1- 6803 Mayfield Rd., Suite 111, Cleveland, OH 44124	800-331-2020 Or 440-720-1285	**does not provide vision screening to individuals; works with centers
Easter Seals Northern Ohio (speech, hearing, and vision)	<ul style="list-style-type: none"> •1929 A East Royalton Rd., Broadview Hts., OH 44147** •14701 Detroit Ave., Lakewood, OH 44107 	440-838-0990 **Central Intake phone #	Medicaid; Private Insurance; Sliding fee scale

* Resources that will train staff and/or come to your location to conduct tests and screenings on children
Please remember to call 2-1-1 for additional information on resources available in Cuyahoga County.



CUYAHOGA COUNTY
Invest in Children



Universal Pre-Kindergarten Health Screening Resources

Please call providers listed above for additional information.

Know what your child's blood lead test results means:

Lead can cause problems with learning, hearing, speech and behavior.

What should I do if I think there is lead in my home?	Contact your local health department to schedule an inspection right away! <i>(see the helpful numbers and websites at the bottom of this page)</i>
Avoid dry dusting or sweeping. Wet mop all floors and window sills.	Make sure your children wash their hands often.
Plant grass to cover bare dirt in the yard. Wash toys when they have been on the ground.	Duct tape over any cracking or peeling paint until a qualified professional removes repairs or covers the lead paint.

<u>What do the lead levels mean and what should I do if my child shows and elevated lead level?</u>	
Blood Lead Value 0-4	<ul style="list-style-type: none"> Your child should be tested for lead once a year until they turn 6 years old. Lead levels less than 5 mean there is low level lead exposure Call your health department to learn more about lead and how to make your home lead safe.
5-9	<ul style="list-style-type: none"> Your child will need a blood test every 2-3 months until the level is less than 5. Schedule this follow-up testing with your doctor's office. A case manager will call or send you a letter with advice about your child's lead level. The other children under 6 years old in your home need to be tested also.
10-19	<ul style="list-style-type: none"> Your child will need a blood test in 1-2 months, and then repeat testing until the number is less than 5. Schedule this follow-up testing with your doctor's office. A case manager from the health department will call to talk about your child's lead level and help you learn more about lead. The health department will want to check your home for lead.
20-44	<ul style="list-style-type: none"> You child will need a blood test in 2-4 weeks, and then repeat testing until the number is less than 5. Schedule this follow-up testing with your doctor's office. A case manager from the health department will talk to you by phone to let you know what to do for your child. Your home may be checked for lead by the health department.
45 or Higher	<ul style="list-style-type: none"> YOUR CHILD <u>MUST</u> GO SEE A DOCTOR OR GO TO THE HOSPITAL TODAY. Your child must be treated with a special medicine to help lower their lead level. Repeat testing 3-4 weeks after treatment. Re-treatment may be necessary. Your home must be checked for lead by the health department as soon as possible. A case manager from the health department can visit your home or talk to you by phone to let you know what to do for your child.

Rainbow Babies and Children's Hospital - www.Rainbow.org/lead
Telephone: 216-844-LEAD (5323)

Cuyahoga County Board of Health Child Lead Poisoning and Prevention Program - <http://www.ccbh.net/lead-poisoning>
Telephone: 216-201-2000 ext. 1215

Cleveland Division of Public Health Lead Safe Living - http://www.clevelandhealth.org/network/enviornment/lead_safe_living.php
Telephone: 216-263-5323

City of Cleveland Lead Hazard Control Program -
<http://www.city.cleveland.oh.us/CityofCleveland/Home/Government/CityAgencies/CommunityDevelopment/DivisionofNeighborhoodServices/LeadHazardControlProgram>
Telephone: 216-263-5323

Ohio Department of Health Lead Poisoning Prevention Program - https://www.odh.ohio.gov/odhprograms/eh/lead_ch/leadch1.aspx
Telephone: 1-877-LEADSAFE (532-3723)



CUYAHOGA COUNTY
Invest in Children



Universal Pre-Kindergarten Health Screening Resources

United States Environmental Protection Agency (EPA) – <https://www.epa.gov/lead>
Centers for Disease Control and Prevention (CDC) – <http://www.cdc.gov/nceh/lead>

Universal Pre-Kindergarten Health Screening Requirement Acknowledgement Form

Dear Parent(s)/Caregiver,

As part of the Universal Pre-Kindergarten program your child must have certain health screenings. These screenings may help prevent future problems with your child’s health. Some of these screenings may be offered by your child’s preschool. If not, a list of resources is attached for those screenings that may not be provided by your child’s preschool.

Thank you!

Below is a list of required screenings

- ❖ Lead screening
- ❖ Hematocrit/Hemoglobin screening
- ❖ Dental screening
- ❖ Vision screening
- ❖ Hearing screening

Your signature below verifies that you are aware of the medical screenings your child needs; confirms that you received the necessary forms for your doctor or dentist to complete; and confirms that you received the list of local resources available to assist you with completing the medical screenings.

Child’s Name

Parent/Caretaker

Date

Site Manager/Representative

Date

Original to Parent

Copy to Child’s File

Income & Residency Verification Form 2021-2022

This form is required to document parents' eligibility for a scholarship based on their gross income and to document that families receiving scholarship assistance are residents of Cuyahoga County. Please attach the document(s) used to verify the parents' income and residency.

Child Care Provider: _____

Name of Child: _____

Document used to verify Caretakers' Total Family Gross Income (please attach):

- Check one: Weekly
 Bi-Weekly
 Monthly
 Bi-Monthly
 Annually

Check all that apply:

- Two most recent check stubs (PREFERRED)
 Prior year's tax return **AND** IRS Form W-2
 Documentation for all unearned income (award letter and/or summary statement)
 Statement/documentation of self-employment
 A copy of the child care authorization letter for subsidized care (Only if \$0 co-pay)

If caretaker did not provide child care authorization letter, residency was documented by (please attach):

- Check one: Most recent check stub with home address
 Current form of identification with address
 Current utility bill

Total Family ANNUAL Gross Income: _____

(Calculate from above OR based on Line 22 from IRS 1040 Tax Return)

Family Size: _____

I attest that all income and residency information is true and accurate, and I will inform the provider of any changes.

Parent Signature

Date

Cuyahoga County Universal Pre-Kindergarten (UPK) Program
NOTICE OF PRIVACY PRACTICES



THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOUR CHILD'S EXPERIENCE IN THE CUYAHOGA COUNTY UPK PROGRAM, ADMINISTERED BY THE OFFICE OF EARLY CHILDHOOD, MAY BE USED AND DISCLOSED. PLEASE REVIEW THIS INFORMATION CAREFULLY. If you have questions about this notice or wish to request additional copies, please contact the Office of Early Childhood at (216) 443-2215.

- I. Who is subject to this notice: This notice describes the practices of the UPK program and that of:
 - 1) Cuyahoga County's Office of Early Childhood
 - 2) Starting Point
 - 3) The individual UPK provider that your child attends
 - 4) Case Western Reserve University (business associate)
 - 5) Pascal Learning Inc./Ready Rosie
 - 6) Educational Services Center of Cuyahoga County
 - 7) PRE4CLE

- II. Our pledge: We understand that information about your child's experience in the UPK program is personal and we are committed to protecting that information. A record of your child's UPK experience is created in order to provide your child with a high quality experience and to help us make improvements to the program. This notice applies to all records created by your child's UPK provider. This notice will tell you about the ways in which we use the information gathered on your child.

- III. Examples of the types of information we collect:
 - 1) Age, gender and race of your child
 - 2) Street address
 - 3) Email address
 - 4) Attendance and enrollment information
 - 5) Assessments of your child
 - 6) Parent involvement in UPK activities
 - 7) Child's special needs, if applicable
 - 8) Other

- IV. Uses:

Information collected about your child and their UPK experience may be used and disclosed as follows:

- 1) By his/her teacher to create a unique learning plan for your child
- 2) By your provider to prepare regular invoices to you for UPK services
- 3) By your provider to prepare invoices to the OEC to be reimbursed for the services provided to your child.
- 4) By your provider to refer your child to additional services in the community

- 5) By the OEC, and their business associate at CWRU, to run the program and make improvements
- 6) By Starting Point to plan support for your UPK provider and to help your UPK provider make improvements to the programs and services you and your child receives

- 7) Email addresses only: By the OEC, and their business associate Pascal Learning Inc./Ready Rosie, to provide parents with brief videos that will help them prepare their children for school. Parents may unsubscribe from the electronic delivery of these emails at any time.
- 8) Email addresses only: By the ESC and Starting Point, to provide electronic newsletters. Parents may unsubscribe from the electronic delivery of those emails at any time.

V. Your Rights Regarding Your Child's UPK records

- 1) You are allowed to inspect and make copies of any records created about your child
- 2) You are allowed to amend your child's record if you feel that there is information in it that is wrong.
- 3) You are allowed to request restrictions or limitations on the uses of the information collected about your child. To request restrictions, you must make your request in writing to the Director of the Office of Early Childhood at the address below. All parent requests will be responded to in writing.

VI. Changes to This Notice

We reserve the right to make changes to this notice. If this notice is changed, you will be advised and furnished with a copy of the revised notice.

VII. Effective Date of This Notice

- 1) The effective date of this notice is August 1, 2017.

Questions/Concerns Contact:

Cuyahoga County
Office of Early Childhood/Invest in Children
Attn: Shawna Rohrman
8111 Quincy Ave., Second Floor
Cleveland, OH 44104 (216) 698-7596

Starting Point

4600 Euclid Avenue Suite 500

Cleveland, Ohio 44103

(216) 575-0061

**ACKNOWLEDGEMENT OF RECEIPT OF THE
NOTICE OF PRIVACY PRACTICES**

Acknowledgement of Receipt of Privacy Practices: I, the undersigned, acknowledge that I have received and have been given the opportunity to review the Cuyahoga County Universal Pre-Kindergarten program Notice of Privacy Practices. I understand that I will be given additional copies of this Notice of Privacy Practices any time at my request.

Please list children enrolled ages 3 to 5 years (not in kindergarten) SITE: _____

First Name	Middle Name	Last Name	Date of Birth

Name of Parent/Guardian _____

Address _____

Telephone () - - () -
Home Work

Signature

Print Name

Date

Original: UPK/PRE4CLE file

Copy: Starting Point
Attn: Julia Garber
4600 Euclid Avenue, Suite 500
Cleveland, OH 44103

Copy: Parent



Universal Pre-Kindergarten COPA Application



Application Date: _____

Child's Name: _____ Birth Date: _____

Gender: (Circle One) Male Female Social Security Number: _____

Language: _____ Ethnicity: (Circle One) Hispanic Latino Neither

Race: (Circle One) African American Asian Bi-Racial/Multi-racial Caucasian

Native American Other Pacific Islander Unspecified

Disability (if applicable): _____ Circle Any Plan Applicable: IEP/IFSP/NCP

Primary Caregiver:

Parent/Guardian Name: _____ Birth Date: _____

Gender: (Circle One) Male Female Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Education Level: _____ Employment Status: _____

Employer/School Name: _____ Income: _____

Employer/School Phone Number: _____

in Family: _____ # in Household: _____ Disability: (Circle One) Yes No

Medical Insurance Carrier: _____

Current Housing: (Circle One) Homeless Own Rent Other

Current Housing Date: _____ Caregiver Relationship to Child: _____

Is there a Secondary Caregiver/ Parent/ Guardian? (Circle One) Yes No

If there is a Secondary Caregiver, complete the next section on Page 2 and sign the verification section. If there is no Secondary Caregiver in the home, then skip the next section and proceed to verification section.



Universal Pre-Kindergarten COPA Application



Secondary Caregiver:

Parent/Guardian Name: _____ Birth Date: _____

Gender: (Circle One) Male Female Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Education Level: _____ Employment Status: _____

Employer/School Name: _____ Income: _____

Employer/School Phone Number: _____

Language: _____ Disability: (Circle One) Yes No

Medical Insurance Carrier: _____

Caregiver Relationship to Child: _____

Verification Section:

I verify that the information on this application is correct.

Parent/Guardian Name : (Print) _____

Signature: _____ Date: _____

Staff Name: (Print) _____

Staff Signature: _____ Date: _____

Ohio Department of Job and Family Services
Ohio Department of Education
EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

Tell us about you (the applicant)			
First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number ()	Additional Phone Number ()	E-mail Address	

Tell us about the people in your home							
Name <i>(First, Middle, Last)</i>	Relationship to You <i>(spouse, son, friend, etc.)</i>	Race	Hispanic or Latino <i>Y or N</i>	Spoken Language	Date of Birth	Gender <i>M or F</i>	U.S. Citizen <i>Y or N</i>
	Self	<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					
		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander					

Tell us about your needs for your child(ren)

Tell us about your needs for your child(ren)			
Child 1	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name			What is the child's home school district?
Child's City of Birth			
Child 2	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name			What is the child's home school district?
Child's City of Birth			
Child 3	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name			What is the child's home school district?
Child's City of Birth			

Tell us about your finances

Will you or the people in your home receive income this month? Yes No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income (before taxes)	How Often Received (weekly, bi-weekly, etc)	Date Last Received	Work or School Schedule (please list times)
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____

Do you or anyone in your household pay Child or Spousal Support? Yes No

How Much?

Signature of Applicant

Date