

Instructions For

St. Joseph County Early Childhood Preschool Application Packet

If you should have any questions please feel free to contact the St. Joseph County ISD – Great Start Program at 269-467-5477

In this packet you will find all the paperwork that **MUST** be filled out to apply for your child to be in either Head Start or Great Start Readiness Program. To determine what program your child qualifies for **ALL** paperwork must be filled out completely. ***Please read carefully what we need to process your application. Any missing information will delay this process.***

Follow step by step:

1. **St. Joseph County Early Childhood Preschool application** – Please fill out all fields. *Do not leave anything blank.*
2. **Head Start and Great Start Readiness Program Income Eligibility Form** – Fill out as accurately as possible. This is extremely important for us to determine which program(s) your child will be eligible to attend. *We will need copies of all of your household income submitted with this packet.*
3. **Early Childhood Risk Factors** – This form is needed to help us determine what your child qualifies for. *Answer all questions in right hand column on the form **except** those under the “For Office Use Only” section.*
4. **St. Joseph County Human Services Commission Consent to Release Information form** – Please fill out with child’s name and birthday in the highlighted areas. *Sign and date where there is an “X” mark at the bottom of form.*
5. **5 Steps To Determine Your Child’s Eligibility** – Parents keep this for your information. You do not need to turn this in with your packet.

Filling out this packet does not mean your child is enrolled. The ISD will determine what program your child qualifies for and will send your paperwork to the appropriate preschool program. They will then be in touch with you to begin enrollment. GSRP will not begin enrollments until after August 1st.



Remember we must have a copy of your child’s birth certificate, parents’ proof of income, and proof of residency (utility bill, rent slip, mortgage payment, etc.).

If you should have any questions please feel free to contact the St. Joseph County ISD – Great Start Program at 269-467-5477.

1. **St. Joseph County Early Childhood Preschool Application**

Child's Name _____ Birth Date _____ Sex _____ Birth Weight _____

Parent/Guardian _____ Birth Date _____ Phone _____ Cell # _____

Address: _____ City _____ Zip _____

Is your current address a temporary living arrangement? _____ yes _____ no

If yes, is this temporary arrangement due to loss of housing or economic hardship? _____ yes _____ no

School District _____ Email: _____

Transportation Needed? ___ Yes ___ No If transportation is unavailable are you willing to transport? ___ yes ___ no

Other adults in the home:

_____ Relationship _____ Birth Date _____

_____ Relationship _____ Birth Date _____

Other children in the family:

_____ Birth date _____

_____ Birth date _____

_____ Birth date _____

Daycare provider _____ Address: _____

Are you a single parent? _____ yes _____ no Divorced? _____ yes _____ no

Annual income (last 12 months) _____ Number in family _____

Do you currently receive Cash Assistance (not food stamps) from Dept. of Human Services (DHS)? ___ yes ___ no

Are you currently employed? Mother _____ yes _____ no Father _____ yes _____ no

Do you or any of your family members receive SSI? _____ yes _____ no

List language (s) spoken in the home _____

Highest grade completed in school: Mother _____ Father _____

Mother's age at birth of first child _____

Does the child have a confirmed disability or receive special education services? _____ yes _____ no

Explain: _____

Have you or any of your children had a long-term or chronic illness? _____ yes _____ no

Who: _____ What: _____

Has your child experienced the death of a parent or sibling? _____ yes _____ no

Do you live in a rural area? _____ yes _____ no

Have any of your children attended: _____ GSRP _____ Head Start _____ Early Head Start

Parent Guardian Signature: _____ Date _____

REVISED JANUARY 2010

Una versión en español de la aplicación de preescolar está en el otro lado del papel.

2. **HEAD START AND GREAT START READINESS PROGRAM
INCOME ELIGIBILITY FORM**

Income: List all income received in the last 12 months. You must list gross income before deductions. **A copy of your earnings must be submitted with this application.** Income must be listed for Employment, Unemployment, Child Support, Alimony, Pensions, Retirement SSI, Disability SSI, DHS Payments (Daycare or Cash Assistance), Subsidized Meals, or you don't have income at this time.

Check ALL that apply and list amount received per year (last 12 months).

- | | |
|------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Employment: _____ | <input type="checkbox"/> Unemployment: _____ |
| <input type="checkbox"/> Child support: _____ | <input type="checkbox"/> Alimony: _____ |
| <input type="checkbox"/> Pensions: _____ | <input type="checkbox"/> Retirement SSI: _____ |
| <input type="checkbox"/> Disability SSI: _____ | <input type="checkbox"/> DHS Day care/Cash Assistance: _____ |
| <input type="checkbox"/> Subsidized Meals | <input type="checkbox"/> Family has no income at this time. |

Household size: (list the number of people living in your household): _____

Documentation Provided:

- Check stub previous year's tax forms DHS child care verification form
- Subsidized meal form with income calculation Other (please specify): _____
- No income documentation at this time.

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for a state-funded Great Start Readiness Program.

Signature of Parent or Guardian

My child cannot participate in GSRP without bus transportation: ____ Yes ____ No

For Office Use Only

- Family appears to be eligible for Head Start or GSRP, but documentation is still needed.
- I verify that I have seen proof of income. Document seen: _____

Signature

Title

Date

*A legislative requirement.

Environmental Risks (continued)	Teen parent	<input type="checkbox"/> Yes <input type="checkbox"/> No – Parent was not yet 20 at the birth of first child.
	Family is homeless or without stable housing	<input type="checkbox"/> Yes <input type="checkbox"/> No – Family is homeless, living in a shelter, or with other families <input type="checkbox"/> Yes <input type="checkbox"/> No – Family home is in foreclosure or there are frequent changes in your residence.
	Residence in a high risk neighborhood	<input type="checkbox"/> Yes <input type="checkbox"/> No – Child experiences daily exposure to environmental pollutants (lead exposure, rodents, insect infestations) <input type="checkbox"/> Yes <input type="checkbox"/> No – Neighborhood has a high crime rate, violence, injury, drug abuse or death rates <input type="checkbox"/> Yes <input type="checkbox"/> No – Home is unsafe or crowded <input type="checkbox"/> Yes <input type="checkbox"/> No – Home has lack of utilities or no space for children’s play.
	Prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays.	<input type="checkbox"/> Yes <input type="checkbox"/> No – Child born with Fetal Alcohol Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No – Child born addicted to drugs <input type="checkbox"/> Yes <input type="checkbox"/> No – Child suffers from respiratory problems because of environment
FOR OFFICE USE ONLY – Parents do not fill out last sections		
Extremely Low Family Income	Extremely low family income	This risk factor is reserved for children eligible for Head start who cannot be served by Head Start, and those just over the Head Start income guideline. This risk factor counts as two risk factors when prioritizing children for enrollment.
Low Family Income	Low family income is between 200% and 300% of federal poverty level	Families are not income eligible for Head Start but are income eligible for GSRP.

**ST. JOSEPH COUNTY HUMAN SERVICES COMMISSION
CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

I hereby authorize the following persons and/or agencies to engage in oral or written communication regarding:

NAME: _____ BIRTHDATE: _____

I am aware that the information to be released is for the purpose of coordinating and planning services. This information will be strictly confidential. If I do not give consent, I will not be denied services. Information will **NOT** be shared or released to any other party except personnel with a legitimate interest without prior written consent. This authorization shall be in effect until revoked in writing or not longer than ***twelve months** or than is reasonably necessary to effect the authorized purpose. Further release of information so shared is prohibited unless consistent with the authorized purpose stated above.

- Instructions: (1) Check "YES" or "NO" if the service provider may share information.
 (2) Look at the **Information Code** below. For each "Yes", list what information may be shared with that agency or by that person by writing the appropriate numbers. If you have special instructions, i.e. only certain documents shared, or information released only to certain people, write them here.

Codes for Type of information

- | | | |
|---------------------------------------------|----------------------------------------------|-----------------------------|
| 1 All Information/Open communication | 6 Initial Assessment/Evaluation Reports | 11 Psychological Reports |
| 2 Discharge Summary | 7 Medical Reports/Date(s) of Hospitalization | 12 Social Histories/Reports |
| 3 Health/Physical Examination | 8 Occupational Therapy Reports | 13 Speech Therapy Reports |
| 4 IEP (Individualized Education Plan) | 9 Physical Therapy Reports | 14 Treatment Plans |
| 5 IFSP (Individualized Family Service Plan) | 10 Progress Reports | |

The following agencies may share information. (Please indicate approval by checking "YES" or "NO").

SERVICE/SERVICE PROVIDER	Yes	No	Type of Information to be shared Special Instructions
1. St. Joseph County Department of Human Services			
2. St. Joseph County Commission on Aging			
3. Guardian Track			
4. Keystone Place			
5. MI Works – Employment Training Connection			
6. Employment Services – (specify)			
7. St. Joseph County Intermediate School District	✓		1
8. CAA – Head Start, Weatherization, Commodities	✓		1
9. Glen Oaks Community College			
10. Local School District (specify)	✓		1
11. KCMH Substance Abuse Services			
12. Community Health Agency			
13. Physician (specify)			
14. Hospital and Affiliated Clinics (specify)			
15. Community Healing Center			
16. Community Mental Health Services			
17. Wraparound			
18. MUST			
19. Community Coordinated Child Care	✓		1
20. Michigan State University Extension Services			
21. Early Childhood Review Team	✓		1
22. Domestic Assault Shelter Coalition			
23. Law Enforcement (specify)			
24. Legal Provider (specify)			
25. Courts (specify)			
26. Legal Aid			
27. Ministerial Association			
28. NAACP			
29. Foster Family			
OTHER (Specify)			

- This form does not permit information about HIV/AIDS and federally funded programs on drug and/or alcohol use/abuse to be shared. A separate authorization to share, specific to this information, must be obtained and signed.
- I understand my feedback is needed in order to plan improvements for eligible children, their families, and other adults and that my name and address may be used to send me consumer surveys.
- My signature also means I have read this form and/or have had it read to me and explained in a language I understand.
- I have the right to revoke this consent at anytime unless the facility which is to make the disclosure of information has already done so in reliance on my consent.

X _____
 Authorizing Person

X _____
 Date

Witness _____

Expires on _____ * See above