Danville
Public Preschool

205 Rambo Street, Danville, Ohio 43014 (740)-599-6116 Fax (740) 599-5904

Dear Preschool Families,

We are so excited to announce changes to our preschool program here at Danville Local Schools!

Next year our preschool program will be relocated to Danville Elementary from Danville's Administration Building. Although we will not be affiliated with the Knox Educational Service Center's preschool program starting the 2020-2021 school year, Miss Jenny and Miss Karen will continue to be our amazing preschool teaching duo, assisting your child with their growth and development in a fun, safe, creative and structured environment!

My name is Cris Dorsey. I am Danville's school psychologist and will be the coordinator for the preschool program. I am very excited to assist children and parents with the transition to preschool! I am here if you should have any challenges or questions along the way. Our team of teachers and specialists are dedicated to assisting your children with their academic, social-emotional and overall growth and development. We are looking forward to meeting your families in the near future!

Enclosed is an enrollment packet to be completed and returned to Danville's Administration Building (405 S Market Street). In the past, after a screening was completed at school, an enrollment packet indicated acceptance into Danville's preschool program. However, with the nation's current health crisis we are requesting that families complete the packets prior to acceptance and return them so we can determine our capacity for both our morning and afternoon programs. We cannot place students in the program until completed paperwork is turned into the administration building. **There is a box located outside the office for preschool paperwork.**

We will inform families by July 1st with acceptance into the morning or afternoon class. If your child is placed on the waiting list we will keep all paperwork submitted in case a spot should open in one of our time slots. **Students will not be placed in a class until completed paperwork is turned into the Administration Building.** Once we are able to determine our start date and plans for the upcoming 2020-2021 school year in regards to the current nation's health crisis, additional information will be communicated.

We are looking forward to serving the preschoolers of Danville!! Please call or email Jenny or myself should you have any concerns or questions.

Jenny Briggs
jennifer.briggs@danville schools.org
740-599-6116 x- (work)
740-263-9725 (cell)

Cris Dorsey
cris.dorsey@danville schools.org
740-599-6116 x-4303
614-791-1819 (cell)

Danville Public Preschool
2020-2021 Enrollment Checklist

Child's Name:

	Application (one time only)
	*Birth Certificate (one time only)
	*Custody Papers (one time only-if applicable)
	*Background Statement
	Emergency Medical Card
	Child Release Information
	Parent Permission Form
	Bus Transportation Release (if applicable)
	Volunteer Form
	Medical Statement/Allergies Form
	Blood Lead Screening Form (First Year Students Only)
	Immunizations
	Dental Forms
	** Early Childhood Eligibility Tool (JFS 01121)
	** Health Check
	** Tuition Agreement with proof of income
	OFFICE USE ONLY
	Registration Fee- $20.00
	* **COPY** to Office **ORIGINALS** to Office

Background Information for Preschool Students

For Office Use Only: Admission Date: _____ Student ID#:_____ IEP: Yes No
Transition Student from "Help Me Grow" Part C Yes No Itinerant – Name:_____
Classroom Name of Classroom _____ Am Pm Full Day
Where Child is being served: _____

Child's Full Legal Name	(First)	(Middle)	(Last)

Home Phone:	Unlisted: Yes No	School District of Residence:	Sex of Child: Male Female

My Child Should Learn To Write His/Her Name As:

Street Address:	City:	Zip:

Mailing Address:	City:	Zip

County:	City, County. & State of Birth:	Date of Birth:	Age:

Previous Preschool:	Address:	Phone: ( )

City:	State:	Zip Code:

Please check if your child is currently receiving any of the following special services:
Occupational Therapy Physical Therapy Speech

Ethnicity & Race Note: The Federal Government requires us to collect the following information:
Part A: Students Ethnicity: Is this student (or are you) Hispanic/Latino? (Choose only one)
☐ No, not Hispanic/Latino
☐ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your student's (or your) race to be.
Part B: Student's Race: What is the student's (or your) race? (Choose one or more)
☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North & South American (including Central America), and who maintains tribal affiliation or community attachment.)
☐ **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.)
☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Native Language (required, check one), this is often the language spoken at home, but should denote the primary language spoken by the student at the onset of speech:
English Albanian Amharic Arabic Cambodian Cantonese Creole (French) German Hmong Japanese Korean Laotian Navajo Portuguese Romanian Russian Serbo Croat Somali Spanish Tagalog Trigtiyan Ukrainian Vietnamese Other

Immigrant Status (Born outside of the states) **Yes No**	Homeless: Yes No	If Yes, Please choose: Sheltered Unsheltered Doubled-Up Hotel/Motel

**REQUIRED INFORMATION (For Preschool Funding) **

INCOME LEVEL
(PLEASE SEE ATTACHED CHART)

0 - 100% 101 - 125% 126 - 150% 151 - 175% 176 - 200% 201% +

FAMILY/CUSTODY INFORMATION

Marital Status of Parents: Married Divorced Separated Mother Deceased Father Deceased
Parents Never Married

Child lives with: Birth Mother and Father Adopted Mother and Father Mother Father
Mother and Step-Father Father and Step-Mother Grandparents Foster Family
Other (Name):

Legal Custody of Student is With (Check One):
Both Parents Mother Father Legal Guardian (Name):

Are there custody papers regarding your child? If "Yes" we will need a complete copy of the papers in your child's file.
☐YES ☐ NO

If student lives with a step parent, does the step parent have permission from the natural parent to act on your behalf in matters regarding the above student? Yes No

Mother's Maiden Name:

1.) Parent/Guardian's Name First & Last Name		Relationship To Child:
Home Phone (if different than child's):	Cell Phone:	Other Phone:
Employer:	Occupation:	Work Phone:
Street Address: Same as child's	City:	Zip
Mailing Address: Same as child's	City:	Zip
Email Address:	Migrant Worker: ☐ Yes ☐ NO	

2) Parent/Guardian's Name First & Last Name:		Relationship To Child:
Home Phone (if different than child's):	Cell Phone:	Other Phone:
Employer:	Occupation:	Work Phone:
Street Address: Same as child's	City:	Zip:
Mailing Address: Same as child's	City:	Zip:
Email Address:	Migrant Worker: ☐ Yes ☐ NO	

3) Parent/Guardian's Name First & Last Name:		Relationship To Child:
Home Phone (if different than child's):	Cell Phone:	Other Phone:
Employer:	Occupation:	Work Phone:
Street Address: Same as child's	City:	Zip:
Mailing Address: Same as child's	City:	Zip:
Email Address:	Migrant Worker: ☐ Yes ☐ NO	

List Others Who Are Living In The Household That Are Not Listed Above (Please use additional paper if necessary):

Name:	Date of Birth:	Relationship to Child:	School:

Signature of Parent/Legal Guardian:	Date:

Child's Name (Last) (First) Nickname (If any)

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff who care for your child.

Who is in the child's family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Yes No? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new homes, death of a family member, friend or pet? Yes No? Additional Details?

Are there any cultural or religious practices of your family of which we should be aware? (dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? Yes No? Additional Details? (center based, in home, with family, with parents, etc.)

How often does your child drink during the day (milk, juice, water, etc.)?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Child Care Licensing requires a form be completed for children with food allergies and/ or dietary restrictions)

Please circle all of the words that best describe your child's personality and behavior:

active, adventurous, affectionate, anxious, bossy, bright, busy, calm, cautious, cheerful, content, creative, curious, easily-angered, emotional, energetic, excitable, friendly, gives-in-easily, happy, hesitant, insecure, jealous, likes structure/routines, loud, mellow, outgoing, prefers adult attention, quiet, sensitive, serious, shares-well, social, spontaneous, stubborn, tentative, other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

Where does your child sit at the table? (high-chair, booster seat, etc.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s) and for how long does your child usually nap?

Does your child have trouble sleeping? (Night terrors, trouble going to sleep, etc.) Yes No? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature **Date**

2020-2021 Danville Public Preschool - Student Emergency Card

Student's Name:

_____ _____ _____ _____ ____/____/____

Last First Middle Home Telephone Number Birth Date

_____ _____

Custodial Parent/Guardian Name Address

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information for emergency calls:

Name	Business Address	Business Telephone	Mobile Telephone
Mother			
Father			

Please list two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name	Address	Home Telephone	Additional Telephone

Please list names of other children in school:

Name	School	Teacher	Grade

HEALTH INFORMATION: List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems, or any chronic conditions, etc.: _____

Preferred Doctor	**Address**	**Telephone**
Preferred Dentist	**Address**	**Telephone**
Preferred Hospital	**Address**	**Telephone**

CONSENT STATEMENT: I, the undersigned, do hereby authorize officials of Danville Public Schools to contact directly the persons named on this card, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature_____ **Date** _____

REFUSAL TO CONSENT: I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take the following action:

Signature_____ **Date** _____

Danville Public Preschool

CHILD RELEASE INFORMATION
2020-2021

I give my permission to release my child, _____ from the center or other related activities (field trips, picnics, etc.), to the following persons:

1. Name _____

   Home Phone: _____ Cell: _____ Work: _____

   Address: _____

   Relationship to Child: _____

2. Name _____

   Home Phone: _____ Cell: _____ Work: _____

   Address: _____

   Relationship to Child: _____

3. Name _____

   Home Phone: _____ Cell: _____ Work: _____

   Address: _____

   Relationship to Child: _____

4. Name _____

   Home Phone: _____ Cell: _____ Work: _____

   Address: _____

   Relationship to Child: _____

_____ _____

Parent Signature **Date**

Danville Public Preschool

2020-2021 PARENT PERMISSION FOR:

CHILD: _____

(Child's Name, printed)

I, _____give permission form my child to:

(Parent's Name, printed)

YES_____ **NO**_____ Field trips to all outings, walks, other trips with the staff.

YES _____**NO**_____ Be included in any photographs/videotaping approved by the teacher or director including publication in a newspaper or the school's website.

YES_____ **NO**_____ According to the State Licensing and Step Up To Quality, all parents may receive a list of parents participating in the program, by request. Please check if you are willing to have your name placed on the roster. (Unlisted phone numbers will not be listed.)

I acknowledge that I have read the above questions and have marked my responses accordingly.

Date: _____

Signature: _____ _____

Parent/Guardian **Relationship to Child**

Danville Public Preschool

TRANSPORTATION INFORMATION

Child's Name: _____

Parent's Name: _____

Home Phone:_____ **Cell:**_____ **Work:**_____

Home Address:_____

PLEASE CHECK ONE:

☐ I WILL TRANSPORT MY CHILD BOTH **TO** AND **FROM** PRESCHOOL

TO SCHOOL:

☐ Please have the bus pick my child up at our home address (Morning only)

☐ Please have the bus pick my child up at the following address:

Name: _____

Home Phone:_____ Cell:_____ Work:_____

Address:_____

Relationship to Child:_____

FROM SCHOOL:

☐ Please have the bus drop my child off at our home address (Afternoon only)

☐ Please have the bus drop my child off at the following address:

Name: _____

Home Phone:_____ Cell:_____ Work:_____

Address: _____

Relationship to Child: _____

Does your child have allergies, handicapping condition(s), or health condition(s) which require special procedures or precautions while on the bus? Yes_____ No_____
If **yes**, please explain: _____
_____
_____

Parent Signature:_____ **Date:**_____

Danville Public Preschool

VOLUNTEER INTEREST SURVEY

The philosophy of the Danville Public Preschool is to involve parents as much as possible in the classrooms. It is certainly a help to the teachers, but more importantly it is a wonderful experience for your child. We hope you will have an opportunity this year to volunteer in the classroom. It can be on a regular basis or whenever your schedule permits.

Please check any of the following areas that you would like to help with:

_____Participate on a parent committee

_____Work with children at computer

_____Help with fund-raisers

_____Help with cooking projects by providing supplies

_____Help in classroom

_____Make materials at home

_____Help with parties

_____Read to children

Parent's Name: _____

Child's Name: _____

Comments: _____

_____

_____

_____

Danville Public Preschool

P.O. Box 30, 10 Rambo Street, Danville, OH 43014 Phone (740) 599-6116 Ext. 4017 Fax (740) 599-5904

MEDICAL EXAMINATION FORM:

Child's Name	Sex	Birthdate
Parent's Name	Phone	

PHYSICIAN'S SECTION – PHYSICAL EXAMINATION ASSESSMENT

	NORMAL	ABNORMAL	COMMENTS
GENERAL APPEARANCE			
SKIN			
HEAD			
EYES			
EARS			
NOSE			
THROAT			
LUNGS			
HEART			
ABDOMEN			
HIPS, FEET AND EXTREMITIES			
GENITALIA			
GROSS NEUROLOGICAL			

RESULTS:	RESULTS:	RESULTS:
BLOOD PRESSURE: SYSTOLIC: _____ DIASTOLIC: _____	HGB/HCT_____ DATE: _____	LEAD SCREENING _____ DATE: _____

Abnormal Findings/Diagnosis:

Treatment Plan Recommended and Follow-up or Results:

This is to certify that I have examined this child and found that:

1) This child has had the immunizations required by section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the state department of health according to the child's age, or is to be exempted from these requirements for medical reasons. (Please note exemptions)_____

IMMUNIZATIONS (enter month, day, and year)					
Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type B (HIB)					
Measles, Mumps, Ruebella (MMR)					
Polio					
Varicella Zoster (Chicken Pox)					
Hepatitis A					
Rotavirus (Recommended)					

2) Based upon medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is in suitable condition to attend a preschool program.

Signature of examining Physician/ Certified Nurse Practitioner	Date of Examination
Name of Physician/ Certified Nurse Practitioner (Please Print)	
Address	Phone:

As required by Rules 5101:2-12-37 and 5101-2-13-37, the child must be examined within twelve months prior to the date of admission.

DOCUMENTED FOOD ALLERGIES or SPECIAL DIET

PART I Family Info (Completed by Teacher)

Center: _____ Telephone: _____

Teacher: _____ Program Year: _____

Child: _____ DOB: _____

Parent's Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

PART II Document Food Allergies or Special Diets (Completed by Medical Authority)

Patient's Name: _____ Age: _____

Diagnosis: _____

_____

_____

Describe the medical or special dietary needs that restrict the child's diet:

_____

_____

_____

_____

Restricted Food(s) to be omitted from diet:

_____

_____

Food(s) that may be substituted for restricted ones are:

_____

_____

Special Instructions: _____

_____

_____

_____

_____

_____ _____

Signature of Physician/Medical Authority* **Date**

BLOOD LEAD POISONING SUMMARY SHEET

CDC RISK ASSESSMENT QUESTIONAIRE
A "YES" ANSWER TO ANY QUESTION MEANS THAT THE CHILD IS **HIGH RISK**

CHILD'S NAME _____ DOB _____ DATE OF ASSESSMENT _____

DOES YOUR CHILD	YES	NO
1. Does your child live or regularly visit an old house build before 1960?		
2. Was your child's day care center/preschool/babysitter's home built before 1960?		
3. Does the house have peeling, chipping, dusting, or chalking paint?		
4. Does your child live in a house built before 1960 with recent, ongoin, or planned renovation or remodeling?		
5. Have any of your children or their playmates had lead poisoning?		
6. Does your child come in contact with an adult who works with lead? Examples: construction, welding, pottery		
7. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead?		
8. Do you give your child any home or folk remedies which may contain lead?		
9. Does your child live near a heavily travelled major highway where soil and dust may be contaminated with lead?		
10. Does your child drink well water?		
11. Does your home have lead pipes, or copper pipes that are soldered with lead?		

BLOOD LEAD SCREENING NEEDED:

Every **high-risk child at time of initial assessment ("YES" to any question)**

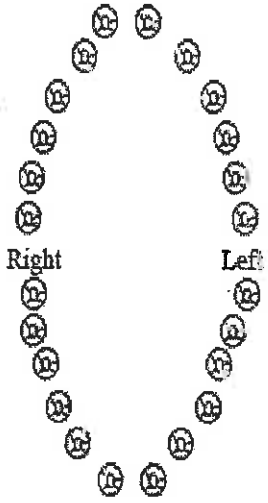
CHILD HEALTH RECORD **DENTAL SCREENING**

PART A

Child's Name:	Sex:	DOB:
Address:		

PART B

ORAL CONDITIONS BEFORE TREATMENT: Missing (Ⓜ) Decayed (●), or filled (Ⓕ)



DENTAL NEEDS
(Check one or more and return to:
KESC Early Childhood Programs)

- ☐ A. TREATMENT (restoration, plub therapy, extraction)
- ☐ B. CLEANING
- ☐ C. FLUORIDE (not mandatory, only by parent consent)
- ☐ D. OTHER
- ☐ E. NO PROBLEMS

Approximate number of visits:_____

PART C

CHILD ORAL HEALTH SUMMARY

All planned treatment _____is/_____ is not completed. If not, explain here as well as items checked:

- ☐ a. Routine recall visits
- ☐ b. Special home emphasis, oral hygiene
- ☐ c. Dietary problem(s)
- ☐ d. Developmental problems
- ☐ e. Harmful oral habits
- ☐ f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part B and C and that itemized charges do not exceed my usual and customary fees.

Signature of Dentist:	**Date of Examination:**

Danville Public Preschool
Attn: Jenny Briggs
PO Box 30, 10 Rambo Street
Danville, OH 43014
Phone: (740) 599-6116 Fax: (740) 599-5904

DENTIST STAMP HERE WITH ADDRESS AND PHONE NUMBER:

ALL DENTAL EXAMS EXPIRE 1 YEAR FROM THE DATE OF EXAMINATION
This is the responsibility of the parent/guardian

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

How do I apply for Early Childhood Education Services (ECC)?	• Complete the screening tool, JFS 01121. • Submit this form to **your provider.** • **Do not** submit the form to the Ohio Department of Education. • Your provider will let you know if you qualify.
How do I apply for Publicly Funded Child Care?	• Complete the screening tool, JFS 01121, and the JFS 01122 Publicly Funded Child Care Supplemental Application, answering as many questions as you can. **Be sure to sign the application.** • Submit both the JFS 01121 and JFS 01122 to your local county agency. • Attach verifications to the JFS 01122 (see verification requirements below). • A verifications checklist will be mailed to you within 10 days of your application date if more information is needed to make a decision on your case. • **You will have 30 days** from the date the county receives your application to provide all needed information.
What verifications do I need for publicly funded child care?	• **Proof of income:** Verification of all money coming into your household (such as pay stubs, tax records, award letters, child support). • **Proof of any child support paid.** • **Proof of citizenship or qualified alien status for children in need of care:** If the county agency verifies that a caretaker receives or has received OWF for a child, verification of citizenship is not required. • **Proof of a qualifying activity for all caretakers in the household:** Verification of a qualifying activity includes but is not limited to an official school schedule, work schedule, employment verification, self-sufficiency contract, etc. • **Provide the name and address of an eligible child care provider chosen for each child in need of care. (See below for tips on choosing a provider).**
What is Step Up To Quality?	**Step Up To Quality helps families identify child care programs that go beyond the minimum standards of licensing. Star Rated programs demonstrate higher levels of quality in a variety of ways. For more information, visit our website at http://jfs.ohio.gov/cdc/index.stm and click on "Step Up To Quality."**
How do I choose a Provider?	**ECC:** If you would like to view a map of early childhood education providers, visit http://education.ohio.gov/Topics/Early-Learning/Early-Childhood-Education-Grant. **Publicly Funded Child Care:** Parents may select any program approved to offer publicly funded child care or early childhood education. These programs include centers, family child care homes and in-home aides located throughout the state of Ohio. • If you would like assistance with selecting a publicly funded child care provider, you may contact your local Child Care Resource and Referral Agency. Visit http://jfs.ohio.gov/cdc/families.stm for contact information. • You may use the ODJFS Child Care Directory to look for programs that fit your child care needs at http://childcaresearch.ohio.gov/. You may search by location, type of program, and by ages of children who need care. You will be able to learn more about each program including Step Up To Quality rating, any additional accreditation or affiliation, and view all licensing inspections and complaints substantiated within the past three years.

Continued on next page

When will my eligibility begin?	**ECC:** You will be notified by your provider when you may begin care. **Publicly Funded Child Care:** Eligibility for the child care program is determined within 30 days from the date the signed application is received by the county. If this application is approved and you are eligible for child care benefits, the county agency may authorize payment for child care from the date the county received this application.
What if my child has a disability or I suspect my child may be developmentally delayed?	• To learn more about Medicaid health screenings and early intervention services for your child, please visit the Ohio Department of Job and Family Services child care website at http://jfs.ohio.gov/CDC/childcare.stm and click on "Families." • **Publicly Funded Child Care:** Your child care provider may qualify for additional assistance if they must make special adaptations for your child. Your provider may contact your county agency for more information.
How do I make a complaint about a provider?	**ECC (ODE):** If the program is licensed by ODE, call 614-466-0224. **Publicly Funded Child Care (ODJFS):** If the program is licensed by ODJFS, call 1-877-302-2347, option 4

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 (First, Middle, Last)	Relationship to You (spouse, son, friend, etc.)	Race	Hispanic or Latino Y or N	Spoken Language	Date of Birth	Gender M or F	U.S. Citizen Y or N
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

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? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ 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? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ 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? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ 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)*
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____

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

How Much?

Signature of Applicant	**Date**

Ohio Department of Medicaid

HEALTHCHEK AND PREGNANCY RELATED SERVICES INFORMATION SHEET

HEALTHCHEK – CHECK IT OUT!

Did you know Ohio's Medicaid program includes **Healthchek** services for children up to 21 years of age? (These services are also called EPSDT sometimes.) **Healthchek** services help children stay healthy and reduce the chances of sickness by treating health problems early. All **Healthchek** services are free. You can get help and information by contacting your county Healthchek Coordinator or your managed care plan and by going to http://medicaid.ohio.gov/FOROHIOANS/Programs/Healthchek.aspx

Screening Services

Doctors want children to have well-child check-ups (screenings) while they are growing up so that health problems can be found early. Check-ups covered by **Healthchek** include:

- Physical check-ups
- Vision checks
- Dental checks
- Hearing checks
- Nutrition screenings
- Mental health screenings
- Developmental screenings
- Immunizations, if needed

Mothers should have at least one prenatal exam and children should have exams at birth, 3 to 5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year. All children should have tests for lead poisoning.

Treatment Services

If the doctor finds a problem during a check-up, the doctor may provide the treatment or may refer you to another doctor. **Healthchek** covers treatment services. Some services may need prior approval. If your child is not in a managed care plan and needs prior approval for a service, your doctor will need to request it from Ohio Medicaid. If your child is in a managed care plan, your doctor will request prior approval from the plan. If you disagree with the decision made by Ohio Medicaid or your child's managed care plan, you can ask for a hearing. Check with your Healthchek Coordinator for more information.

Support Services

The names, addresses and phone numbers of Healthchek Coordinators for all counties can be found at http://medicaid.ohio.gov/Portals/0/For%20Ohioans/Programs/countycoordinators.pdf or by calling your County Department of Job and Family Services. If you need to find a doctor, dentist or other health care provider, your county Healthchek Coordinator can give you a list. Your Healthchek Coordinator can also help you make doctor's appointments and help you get transportation to the doctor. If your child is in a managed care plan, the plan can also help make doctor's appointments and may provide transportation to the doctor. The plan can also give you a list of doctors in their plan. You can go to the plan's website for more information.

You can ask your Healthchek Coordinator to make referrals for you to Head Start, the Women, Infants, and Children (WIC) program, Help Me Grow, and the Bureau for Children with Medical Handicaps. Your Healthchek Coordinator can give you names of other agencies that can help you get clothing, housing, food, and other services. You may also submit questions using an online form found at http://medicaid.ohio.gov/CONTACT.aspx.

Ohio Department of Medicaid

HEALTHCHEK AND PREGNANCY RELATED SERVICES INFORMATION SHEET

Please fill out the following information in order to help us provide Healthchek services to you and/or your child. If you do not understand some or all of this form, please contact your county Healthchek Coordinator. **Please return this Information Sheet to the Healthchek Coordinator at your County Department of Job and Family Services, or mail it back in the envelope included with this packet. Please keep the cover letter for your records so you can refer to it again.**

Your Information

First Name	Last Name			
Case Number	Street Address, Apt. No.			
City	State	Zip Code	County	Date of Birth
Email	Telephone Number			

Your Child's Information

Child's Name	SSN or Medicaid Billing No.
Child's Name	SSN or Medicaid Billing No.
Child's Name	SSN or Medicaid Billing No.
Child's Name	SSN or Medicaid Billing No.

Is your child enrolled in a Medicaid managed care plan?

☐ Yes. Plan

☐ No. Before enrolling in a plan, make sure your (or your child's) doctors or clinics are on the plan's list of providers.

Healthchek Screening Services

Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone on Medicaid and under 21 years of age. It also covers complete medical, vision, dental, hearing, nutritional, psychological, and mental health exams. These exams are important to make sure that your child is healthy and is developing physically and mentally. Mothers should have at least one prenatal exam and children should have exams at birth, 3 to 5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one **Healthchek** exam per year until 21 years of age. **Please check all services you or your child would like to receive.**

☐ A comprehensive medical exam
☐ A vision (eye) exam
☐ A hearing exam
☐ A mental health exam
☐ A dental (tooth) exam:
☐ A specialist exam:

Healthchek Treatment Services and Transportation to Health Care Appointments

Healthchek covers tests and treatment services to treat problems or conditions found by an exam. Some tests and treatment services require pre-approval. If you need pre-approval, your provider must ask Ohio Medicaid or your managed care plan.

Your Healthchek Coordinator can help you make medical, dental and other appointments and provide free transportation to those appointments, if needed. If you or your child is enrolled in a managed care plan, the plan can also help with appointments and provide transportation. It can also give you a list of doctors in your plan. In order to make sure that you and your child get what you both need, **please check everything you or your child would like to receive.**

☐☐ A list of doctors
☐☐ A list of dentists
☐☐ A list of other healthcare professionals
☐☐ Other help getting treatment
☐☐ Transportation to medical or dental appointments
☐☐ Referrals to Help Me Grow
☐☐ Referrals to the Bureau for Children with Medical Handicaps
☐☐ Other information about where to get treatment

Do you or your child have any problems that need attention or treatment (for example, a medical problem, a mental health problem, a child who is not developing normally, etc.)? If so, please tell us more about this. ____

Other information about your child's history

My child has been tested for lead poisoning	☐☐ Yes	☐☐ No	☐☐ Don't know
My child's immunizations (shots) are up-to-date	☐☐ Yes	☐☐ No	☐☐ Don't know
My child has had developmental exams	☐☐ Yes	☐☐ No	☐☐ Don't know

Support Services

Your Healthchek Coordinator can also give you information about available services like the Women, Infants, and Children (WIC) program and other services offered through your local health department and other local agencies.

Would you like more information about other services? Please check all that apply.

☐☐ Women, Infants and Children (WIC)
☐☐ Heating Assistance
☐☐ Other:
☐☐ Food Assistance
☐☐ Head Start

Is anyone in your family (including yourself) pregnant? ☐☐ Yes ☐☐ No
If YES, give the name(s) of the pregnant woman.
If known, give the date(s) the baby is due: Month Year
Is the pregnant woman now going to a doctor or clinic for the pregnancy? ☐☐ Yes ☐☐ No
If YES, give the name of the doctor or clinic.
Do you need other social services? ☐☐ Yes, Specify: ☐☐ No
Are you currently enrolled in a managed care plan or HMO? ☐☐ Yes ☐☐ No
If YES, specify name of plan or HMO.

(Note: Before you enroll in an HMO, be sure that your doctor or clinic is on the HMO's list. If you enroll in an HMO in the future, be sure to tell the HMO staff about the services you would like to get.)

Acknowledgement

I have been given information about Healthchek. I understand that I can ask for Healthchek services or assistance at any time. I understand that I will be asked to sign a separate release form if my medical information needs to be shared with others.

Signature		Date
Caseworker Signature	Date	Phone
Caseworker Email		

Caseworker: Please forward this information to the appropriate Medicaid managed care plan.

Danville Public Preschool

Over-income families who do not receive a reduced tuition based on the sliding fee scale do not need to disclose income. They will be charged the full tuition about of $150 per month. Please check if over income _____

FEE AGGREMENT

I, _____ agree to bring my child _____ to the Danville Public Preschool Program at a fee of $ _____a month. The fee is a tuition and non-fundable for absences. These fees have been set in accordance with my latest income information. I agree to inform the Danville Public Preschool Program of any changes in the income figures listed on the back of this form, or if I am unable to make my monthly payment for any reason. I understand that the fee is to be paid by the 1st of each month, September – May.

Signature _____ Date _____

Verified by: _____

Date: _____

0 – 100%	151 – 175%
101 – 125%	176 – 185%
126 – 150%	186 – 200%
201%+	

Please mark tuition level here.

United States Department of Health and Human Services
2020 FEDERAL POVERTY GUIDELINES *

*Annual Family Income
*See ODE 2020 Federal Poverty Guidelines for additional family members

Size of Family Unit	100% or Below Poverty Level	101-125% Poverty Level	126-150% Poverty Level	151-175% Poverty Level	176-185% Poverty Level	186-200% Poverty Level	201%+ Poverty Level
1	0 - 12,760	12,761 - 15,950	15,951 - 19,140	19,141 - 22,330	22,331 - 23,606	23,607 - 25,520	25,521
2	0 - 17,240	17,241 - 21,550	21,551 - 25,860	25,861 - 30,170	30,171 - 31,894	31,895 - 34,480	34,481
3	0 - 21,720	21,721 - 27,150	27,151 - 32,580	32,581 - 38,010	38,011 - 40,182	40,183 - 43,440	43,441
4	0 - 26,200	26,201 - 32,750	32,751 - 39,300	39,301 - 45,850	45,851 - 48,470	48,471 - 52,400	52,401
5	0 - 30,680	30,681 - 38,350	38,351 - 46,020	46,021 - 53,690	53,691 - 56,758	56,759 - 61,360	61,361
6	0 - 35,160	35,161 - 43,950	43,951 - 52,740	52,741 - 61,530	61,531 - 65,046	65,047 - 70,320	70,321
7	0 - 39,640	39,641 - 49,550	49,551 - 59,460	59,461 - 69,370	69,371 - 73,334	73,335 - 79,280	79,281
8	0 - 44,120	44,121 - 55,150	55,151 - 66,180	66,181 - 77,210	77,211 - 81,622	81,623 - 88,240	88,241

Income Level	100% or Below Poverty Level	101-125% Poverty Level	126-150% Poverty Level	151-175% Poverty Level	176-185% Poverty Level	186-200% Poverty Level	201%+ Poverty Level
Tuition Per Child Per Month	**FREE**	**$40**	**$60**	**$80**	**$**	**$**	**$150**

Total Amounts:

Month _____ **Year** _____ **Members in Family** _____

Families receiving a reduced tuition rate based on the sliding fee scale must present records to verify income. If you are receiving a reduced tuition based on the sliding fee scale, please complete the following:

I, the undersigned, do hereby certify that the total household income is as follows:

Wages/Gross Earned Income gross/month _____ gross/year _____
gross/month _____ gross/year _____

(Gross Earned Income: the total of gross earnings received in a month by all of the employed individuals in the family. These include payments received before taxes and other deductions, for services performed as an employee, or by an individual as a result of self-employment. State temporary disability insurance and temporary workers' compensation payments are considered gross earnings.)

Items excluded:

*The gross earnings of a minor child in the family who is a full time student as defined by the school, unless the minor is a parent. Child Support payments paid by a family member for a child outside the family. The amount paid, up the amount ordered, is excluded. *Alimony paid pursuant to a court order. *The verified amount that is being garnished from the income. *Earned Income Tax Credit (EITC) payments when added to the individual's wages. *Earnings received for participation in the Americorp Vista Program.
Any other income amounts that federal status or regulations require to be excluded.

Gross Unearned Income month _____ year _____
month _____ year _____

Unearned income is income that is not gross earned income from employment or self-employment. Unearned income includes cash contributions received by the family from persons, organizations or assistance agencies.

Items Excluded:

*Income of a recipient of Supplemental Security Income (SSI), including the SSI payment and earned income. *Income of a child for whom federal, state, or local foster care maintenance payments are made, including the foster care payment. * Income of a child for whom federal, state, or local adoption assistance payments are made, including the adoption assistance payment. * Child support payments paid by a family member for a child outside the family. The amount paid, up to the amount ordered, is excluded. *Alimony paid pursuant to a court order. * Income tax refunds received by any of the family members. * The verified amount that is garnished from the income. * Any other income amounts that federal statutes or regulations require to be excluded.

Verification Sources: Pay stubs, receipts, W-2's, 1099's, income taxes, etc.