



# Danville Public Preschool

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

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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
	Parent Handbook
	Medical Statement/Allergies Form
	Blood Lead Screening Form (First Year Students Only)
	Immunizations
	Dental Forms
	Early Childhood Eligibility Tools (JFS 01121)
	Health Check
	Tuition Agreement with proof of income
	<b>OFFICE USE ONLY</b>
	Registration Fee - \$20.00

## 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    Trigriyan    Ukrainian    Vietnamese    Other

Immigrant Status (Born outside of the states) <b>Yes</b> <b>No</b>	Homeless:	If Yes, Please choose:		
	Yes    No	Unsheltered	Doubled-Up	Sheltered 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 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. <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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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?

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**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			
<b>RESULTS:</b> BLOOD PRESSURE: SYSTOLIC: _____ DIASTOLIC: _____	<b>RESULTS:</b> HGB/HCT _____ DATE: _____		<b>RESULTS:</b> 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, Rubella (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 QUESTIONNAIRE**

**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 built 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, ongoing, 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?			

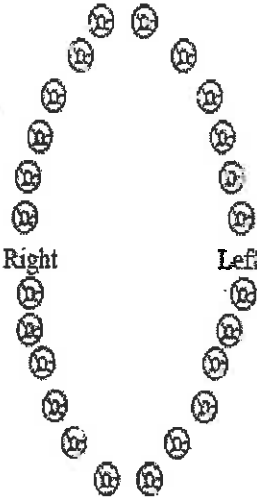
**BLOOD LEAD SCREENING NEEDED:**

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

**PART A**

Child's Name:	Sex:	DOB:
Address:		

**PART B**

<p><b>ORAL CONDITIONS BEFORE</b>                  TREATMENT: Missing (☉)                  Decayed (●), or filled (⊙)</p> <div style="text-align: center; margin: 20px 0;">  </div>	<p style="text-align: center;"><b>DENTAL NEEDS</b>                  (Check one or more and return to:                  KESC Early Childhood Programs)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A. TREATMENT (restoration, plub therapy, extraction)</li> <li><input type="checkbox"/> B. CLEANING</li> <li><input type="checkbox"/> C. FLUORIDE (not mandatory, only by parent consent)</li> <li><input type="checkbox"/> D. OTHER</li> <li><input type="checkbox"/> E. NO PROBLEMS</li> </ul> <p style="text-align: right; margin-top: 20px;">Approximate number of visits: _____</p>
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**PART C**

<b>CHILD ORAL HEALTH SUMMARY</b>	
All planned treatment _____ is/ _____ is not completed. If not, explain here as well as items checked:	
<input type="checkbox"/> a. Routine recall visits	<input type="checkbox"/> c. Dietary problem(s)
<input type="checkbox"/> b. Special home emphasis, oral hygiene	<input type="checkbox"/> d. Developmental problems
<input type="checkbox"/> e. Harmful oral habits	
<input type="checkbox"/> 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.	
<b>Signature of Dentist:</b>	<b>Date of Examination:</b>

**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



## EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

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### 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.

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### 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.

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### 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).**

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### 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."**

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### 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.

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Continued on next page

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**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.

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**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.
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**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

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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)**

<b>Tell us about your needs for your child(ren)</b>			
<b>Child 1</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours/days do you need services? (i.e. child care or preschool) Check all that apply</b>
<b>Name</b>		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
<b>Child's Mother's Maiden Name</b>			<b>What is the child's home school district?</b>
<b>Child's City of Birth</b>			
<b>Child 2</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours/days do you need services? (child care or preschool) Check all that apply</b>
<b>Name</b>		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
<b>Child's Mother's Maiden Name</b>			<b>What is the child's home school district?</b>
<b>Child's City of Birth</b>			
<b>Child 3</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours/days do you need services? (child care or preschool) Check all that apply</b>
<b>Name</b>		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
<b>Child's Mother's Maiden Name</b>			<b>What is the child's home school district?</b>
<b>Child's City of Birth</b>			

**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

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 Healthcek 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)  Food Assistance  
 Heating Assistance  Head Start  
 Other:

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 Healthcek. I understand that I can ask for Healthcek 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 amount of \$150 per month. Please check if over income \_\_\_\_\_

## FEE AGREEMENT

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 1<sup>st</sup> 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	<b>FREE</b>		<b>\$40</b>		<b>\$60</b>		<b>\$80</b>		<b>\$ 100</b>		<b>\$ 125</b>		<b>\$150</b>

**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 to 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.