

APPLICATION FOR PRESCHOOL PROGRAMS

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| San Ysidro School District Preschool & Child Development 1880 Smythe Avenue, San Ysidro, CA 92173 (619) 428-2352 | Child's Name: _____ _____ Last Name First Name Middle Name |
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OFFICE USE ONLY/SOLO USO DE OFICINA (2023-2024)

SITE/LOCATION: CDC/PS OVH Sunset

PROGRAM: State Preschool* (See reverse for disclosure) QPI Other: _____

APPLICATION: Complete Date _____

PLEASE PRINT CLEARLY / POR FAVOR ESCRIBA CLARAMENTE

| | | | |
|---|------------|--|-------------------|
| FAMILY IDENTIFICATION: If you are a <u>single parent/caretaker</u>, check this box <input type="checkbox"/> | | | |
| CHILD LIVES WITH: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian =relationship to child _____ | | | |
| PRINT Full Name of Mother /Caretaker A. | Sex | Phone No. (Home) | Phone No. (Cell) |
| PRINT Full Name of Father / Caretaker B. | Sex | Phone No. (Home) | Phone No. (Cell) |
| Home Address: _____ | Apt: _____ | City _____ | State Zip Code |
| E-Mail Address (Mother/Caretaker): _____ | | E-Mail Address (Father/Caretaker): _____ | |

| DATA ON CHILDREN. List <u>all your children</u> residing in the home and counted in the family size. | | | | | | | | |
|--|------------|---|------------------|--|--------------------|-------------|--|---------------------|
| Complete for your children that are residing in the home PLEASE PRINT | | | | FOR OFFICE USE ONLY | | | | |
| | | | | Complete only for children served by your agency | | | | |
| (1) FULL NAME OF CHILDREN Please write the name of the child(ren) being enrolling first, then the siblings. | (2) SEX | | (3) BIRTHDATE | (4) ADJUSTMENT FACTOR CODE | (5) ETHNIC CODE | (6) RACE | (7) NATIVE LANGUAGE | (8) PROGRAM CODE |
| | M | F | MM / DD / YYYY | | | | LANGUAGE CODE Limited English proficient? | |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |

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|---|---|
| PLEASE COMPLETE THE FOLLOWING: | |
| Ethnicity: Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race: Please check <input checked="" type="checkbox"/> one or all that apply (Federal requirement data) | |
| <input type="checkbox"/> American Indian (100) <input type="checkbox"/> Korean (203) <input type="checkbox"/> Cambodian (207) <input type="checkbox"/> Samoan (303) <input type="checkbox"/> Alaskan Native (100) <input type="checkbox"/> Vietnamese (204) <input type="checkbox"/> Other Asian (299) <input type="checkbox"/> Tahitian (304) <input type="checkbox"/> Chinese (201) <input type="checkbox"/> Asian Indian (205) <input type="checkbox"/> Hawaiian Native (301) <input type="checkbox"/> Other Pacific Islander (399) <input type="checkbox"/> Japanese (202) <input type="checkbox"/> Laotian (206) <input type="checkbox"/> Guamanian (302) <input type="checkbox"/> Filipino (400) | <input type="checkbox"/> African American/Black (600) <input type="checkbox"/> White (700) <input type="checkbox"/> Hmong |
| Special Services: <input checked="" type="checkbox"/> Check any applicable services your child has received: <input type="checkbox"/> No Special Services Needed | |
| <input type="checkbox"/> Deaf/Hard of Hearing <input type="checkbox"/> Speech & Language <input type="checkbox"/> Counseling <input type="checkbox"/> Behavioral Services <input type="checkbox"/> Adapted Physical Education <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Other _____ |

FOR OFFICE USE ONLY

MUST BE SIGNED AND DATED BY PARENT/GUARDIAN BEFORE SUBMITTING

CERTIFICATION AND SIGNATURE OF PARENT/GUARDIAN

- | | |
|--|---|
| 1. I declare under penalty of perjury that the above information is true and correct to the best of my knowledge. | 5. I understand the agency may contact my employers and/or any sources of my declared income to verify the information submitted as part of this application. |
| 2. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child development services. | 6. I understand that I must renew my eligibility at least once per year. I further understand that if I do not renew my eligibility, I will no longer be eligible for subsidized preschool & child development services for my child. |
| 3. I understand that the information about my eligibility may be reviewed by representatives of the State of California, the Federal Government, Independent auditors, or others as necessary for the administration of the program. | 7. I understand that I will receive a notice of approval or disapproval of my application within 30 days from the date I sign this form. |
| 4. I understand that if the agency denies this application for services, I have the right to appeal. | 8. I understand that this certification is not complete until all documentation is submitted and this form has been reviewed, signed, and dated by an agency representative and signed and dated by me. |

SIGNATURE _____

DATE _____

RELATIONSHIP TO CHILD:

Parent Grandparent Guardian Foster Parent

Other: _____

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*** DISCLOSURES: STATE PRESCHOOL PROGRAM ONLY**

**STATE PRESCHOOL PROGRAM
CONFIDENTIAL APPLICATION FOR
CHILD DEVELOPMENT SERVICES AND
CERTIFICATION OF ELIGIBILITY
ELCD 9600 (Rev. 12/17)**

Agency Name: San Ysidro Elementary School District

Family Identification/Case No.: _____

Initial Subsidized Service Date: _____

Note: State regulations require a formal application and certification for child development services. You will receive written notice of your eligibility no later than 30 days from the date of your signature of this form. Eligibility is determined on the basis of need for child development services and either CalWORKs status or adjusted gross monthly income in relation to family size. This form must be completed by an agency representative in consultation with the family. Refer to the instructions for the completion of this form.

FAMILY ELIGIBILITY STATUS (Check as many as apply)

***State Preschool Program**

- | | |
|--|--|
| <input type="checkbox"/> Income Eligible (Attach Documentation) | <input type="checkbox"/> 24-Month Eligibility (San Diego County Pilot Plan) |
| <input type="checkbox"/> Protective Services (Attach Documentation) | <input type="checkbox"/> Homeless (Attach parent's statement) |
| <input type="checkbox"/> Severely Handicapped programs (GHAN) | |

Quality Preschool Initiative (QPI)

Head Start

Other _____

FAMILY ADJUSTED GROSS MONTHLY INCOME AND SIZE

A. Family Monthly Income – Family's adjusted monthly income from all sources.
(Attach verification, documentation & calculation sheet.)

\$ _____ 85% Over Rank # _____

B. Family Size: _____

Certification is not complete until eligibility is reviewed, signed and dated by an agency representative.

| | | | | |
|---|--|--|----------------------------------|-------------------------|
| ELIGIBILITY STATUS: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied | Date Notice of Action Sent (Attach copy) | Date Notice of Action Given (Attach copy) | First date of subsidized service | Last date of enrollment |
| SIGNATURE OF AUTHORIZED AGENCY REPRESENTATIVE | TITLE <input type="checkbox"/> Director <input type="checkbox"/> Secretary | Telephone Number (619) 428-2352 | Date | |