

Dear Parents,

Thank you for your interest in the Bellevue City Schools public preschool program. The preschool application is attached.

Application Directions:

- 1) Please be sure to fill out every page of the application completely. You **must** provide the names and phone numbers of 2 emergency contacts and a doctor and dentist on the Emergency Medical Authorization Form.
- 2) The following documents **MUST** be submitted with the application. **Applications will not be processed with documents missing.**
 - Verification of Income - Verification can be in the form of a pay stub, W-2, 1040 tax form, or statement of other benefits (for example, Social Security, SSI, unemployment, public assistance, etc.) Applications **will not** be processed without this information. Preschool tuition is based on a sliding fee schedule according to family size and income. **Enrollment priority is given to income eligible families.** Income eligibility is based on annual gross income and total number of family members living in your home.
 - Copy of your child's certified birth certificate***
 - Proof of residency*** (Copy of current utility bill or account statement, lease agreement, or real estate tax bill with name and address on it)
 - Custody papers, if applicable******Returning students do not need to provide this information unless there have been changes from the previous school year.
- 4) A \$30.00 non-refundable supply fee may be due once your child is accepted into the preschool program. **Do not send any money with the application.** You will be billed for this at a later date, if applicable to your family.
- 5) The **Child Medical Statement** and **Dental Health Record** can be turned in later. **The Child Medical Statement**, with a list of current immunizations, will need to be filled out by your child's physician. If your child does NOT have a regular medical provider, please inform the school nurse or your child's teacher so that we may assist you in locating a provider. The **Dental Health Record** will need to be filled out by your dentist. Once these forms are completed, please forward them to the address below. You can send the Preschool Application in before the health forms are completed. If your child is returning to the preschool program for a second year, the Dental Health Record is not required. Returning students will need to have an **updated physical within 13 months** of their previous preschool physical.

The Child Medical Statement and Dental Health Record for first time students must be turned in within 30 days of beginning preschool. If these are not turned in within 30 days, your child will not be able to attend preschool.

Please note that a lead and hemoglobin screening are now required for preschool as part of the physical examination. A copy of *Lead Testing Requirements and Medical Management Recommendations* per Ohio Department of Health is included. **Bellevue is a High Risk zip code requiring lead testing.** If your child has already been screened, please provide a copy of the results for your child's file. If your child has NOT yet been screened as required, please discuss the need to do so with your child's physician/health care provider and forward the results to school nurse. The purpose of this policy is to ensure the children's safety as much as possible.

- 6) Please return the required application materials and verification of income document to:
Bellevue Elementary School, 1150 Castalia Street, or
Bellevue City Schools Board of Education, 125 North Street Bellevue, OH 44811
*Applications will be dated and processed in the order received.

If you have any questions regarding the preschool program, please call Bellevue Elementary School, 419-484-5050.

*Bellevue City Schools Preschool Program
Bellevue Elementary School
1150 Castalia Street
Bellevue, OH 44811
419-484-5050*

PROGRAM INFORMATION

The Bellevue City Schools Preschool Program is located at Bellevue Elementary School. The preschool program offers morning and afternoon sessions Monday through Friday. The morning class meets 9:00-11:45a.m., while the afternoon class meets 12:30-3:15 p.m. Parents wishing to enroll their child for less than five days per week should speak with the preschool supervisor.

PROGRAM PHILOSOPHY

The BCS preschool program is based on the following research-based beliefs:

- Each child is a unique individual and must be appreciated and valued for his/her individuality.
- Children grow and develop at different rates and each child's rate is separate and distinct from that of any other child.
- Children are naturally curious and eager to learn. They learn best when they are able to follow many of their own interests and desires to learn.
- Learning is active - something a child does, rather than something that is done for him or her.
- Play is a child's "job" and way of learning.
- Children learn from each other. As they learn, children develop a sense of responsibility and achievement. They learn to respect themselves and others.
- Confidence is developed in an atmosphere of trust where children can try new things and learn to solve problems.
- A rich learning environment, one deliberately designed with much to explore and discover, is essential in helping young children learn basic skills. Concrete and sensory materials are important in this environment, as they are basic learning tools for the young child.
- The most important variable in a young child's learning is the educator. Parents are a child's first and most important educator.

The BCS preschool program provides for the development of the whole child - physically, emotionally, socially, and intellectually. The program is licensed by the Ohio Department of Education (ODE). The curriculum is aligned with the Ohio Early Learning and Development Standards. We provide activities to encourage learning in the way that children learn best – through interaction with other children and caring adults in a supportive environment. Activities are planned to meet the needs and abilities of each child in the class.

Our goal is to provide your child with a positive first school experience where she/he enjoys learning. Together, we can build your child's foundation for a lifetime of learning!

VERIFICATION OF INCOME

Name of Child

Birthdate

Verification of current employment and salary is needed in order to determine the preschool program tuition for your child.

List all household members and their family relationship

_____	_____
_____	_____
_____	_____
_____	_____

Total yearly gross household income _____

Please attach one of the following:

- _____ W-2
- _____ 1040 Tax Form
- _____ Check stub
- _____ Other _____

Child is eligible for medical card: YES NO

SNAP or ODJFS financial assistance case number (if applicable) _____

Print name of parent/guardian

Street address, City, Zip

Home phone number

Penalties for misrepresentation

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for receipt of state funds, that program officials may verify the information on the application, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

Signature of parent/guardian

Date

For Office Use

Signature of person verifying income

Date

CONSENT TO RELEASE CHILD'S PHOTO/VIDEO AND OTHER INFORMATION

To publicize the achievements of our preschool students and the great work they do, we like to occasionally publish our students' photos, activities, and/or achievements in our school publications or release the information to local newspapers. We may also post the information on the school's website. Student names will NOT be included with photos or news stories.

We understand that you may not want to have your child's photo, activities, and/or achievements published. Please fill out this form to let us know your wishes.

School district _____ Classroom teacher _____

Student's name _____

- I consent to have my child's photo, activities, and/or achievements published in school newspapers/newsletters, release to local newspapers, and posted on the school's website as it relates to activities and participation in the preschool program.
- I do not want my child's photo, activities, and/or achievements published in school newspapers and/or newsletters, released to local newspapers or posted on the school's website.

Signature of parent/guardian

Date

Signature of parent/guardian

Date

For Office Use

Signature of preschool teacher

Date

EMERGENCY MEDICAL AUTHORIZATION FORM

Child's name _____ Grade Preschool
Home Phone _____ Cell Phone _____
Address _____
School district _____ Building _____

The purpose of this form is to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for your child who becomes ill or injured while under school authority, when you cannot be reached.

Residential parent(s)/guardian(s)

Mother/guardian name _____ Phone:Work _____ Home _____ Cell _____
Father/guardian name _____ Phone:Work _____ Home _____ Cell _____

Contact information if parents cannot be reached in case of emergency: **(2 contacts required)**

Name _____ Relationship _____
Phone Number _____ Cell Number _____
Address _____

Name _____ Relationship _____
Phone Number _____ Cell Number _____
Address _____

PART I OR PART II MUST BE COMPLETED

Part I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called.

Physician _____ Phone _____
Dentist _____ Phone _____
Medical specialist _____ Phone _____
Local hospital _____ Emergency room phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

List below facts concerning your child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Signature of parent/guardian _____ Date _____
Address _____

Part II: 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 the school authorities to take the following action _____

Signature of parent/guardian _____ Date _____
Address _____

DENTAL HEALTH RECORD

Child's name _____ DOB _____ School _____

Parent/guardian name _____ Phone _____

Address _____

1. Has the child previously seen a dentist? No Yes Dentist's Name _____

2. Does the child have any trouble with teeth, gums, or mouth? No Yes

3. Oral condition before treatment: Missing Decayed Filled

4. Examination and treatment record

tooth letter	surface	description of work	date service performed	procedure number

8. Is baby bottle tooth decay present? No Yes

9. Is the child receiving: Topical Fluoride Application? No Yes
 Fluoride Supplement Diet? No Yes If yes, tablets ___ liquid ___
 Fluoridated water? No Yes

10. Is all planned treatment complete? No Yes If not, itemize on chart below.

tooth letter	surface	description of work

11. Approximate number of visits required for treatment? _____

12. Next scheduled appointment _____

13. Comments: _____

Dentist's Name _____

Street Address _____

City, State, Zip _____ Phone _____

Dentist's Signature _____ Date of examination _____



**BELLEVUE CITY SCHOOLS
PRESCHOOL PROGRAM
INTEREST SURVEY
2017-2018 School Year**

Dear Families,

To help us understand and better communicate with your child, please take a few minutes to complete this Interest Survey. The information will help us be able to make your child feel more at ease at school.

Child's Name: _____ Nickname _____

Child's name as you want them to recognize it in print: _____

Brother's/Sister's Name(s) and Ages: _____

Babysitter's Name: _____

Friend's Name(s): _____

Favorite Toy(s): _____

Favorite Food(s): _____

What does he/she call grandparents? _____

Any pets and their names: _____

Any other people, events, etc. your child especially likes/dislikes to talk about: _____

Is there anything of which your child is fearful? If so, what are some ways he/she is calmed?

What are your hopes for your child's preschool experience this year? (What is most important to you, such as experiences, opportunities, skills, etc.?) _____

What hobbies or special skills would you be willing to share? _____

Bellevue City Schools Home Language Survey

Date: _____

Name of Student _____

Date of Birth: _____ Place of Birth: _____

Name of Parent/Guardian: _____

Home Address: _____

City: _____ State _____ Zip _____

**For Parents/Guardians:
Please answer the following questions:**

1. What language did your son or daughter speak when he or she first learned to talk?

2. What language does your son or daughter use most frequently at home?

3. What language do you use most frequently to your son or daughter?

4. What language do the adults at home most often speak?

5. How long has your son or daughter attended school in the United States?

For School District Personnel:

If the answer to any of the first four questions above is a language other than English, indicate the student's native/home language in EMIS Student Data Element (G1270), and proceed to assess the student's English language proficiency.

CHILD MEDICAL STATEMENT

Bellevue Schools Early Childhood Education Program

Child's Name (Print or Type) _____	Date of Birth _____
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Height _____ Weight _____ BMI (percentile) _____

Required Medical Screenings for Children Enrolling in ECE Preschool Program			*Reason if not completed (Check which applies)		
Screening	Completed Circle one		Date Completed	Health professional decision	Examples, religious conviction, insurance coverage, other
Lead	YES	NO			
Hemoglobin	YES	NO			

Physician/ PA/ APN/ CNP to complete. Check all that apply for each disease. **Attach a copy immunization record.**

Diseases for Immunization	Immunized (Up to date for age)	In Process of immunization	Medically Contraindicated/ Not age appropriate (List specific vaccine component if indicated)	Parent/guardian initial for specific immunization declined.
Diphtheria/Tetanus/Pertussis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Haemophilus Influenzae B (HIB)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hepatitis A	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Measles/Mumps/Rubella	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pneumococcal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Poliomyelitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Varicella (Chicken Pox) <input type="radio"/> Had chicken pox disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Influenza <input type="radio"/> Seasonal vaccine not available	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

I have declined to have this child immunized against one or more of the diseases required by Ohio Revised Code for religious convictions. Initial beside the disease(s) being declined and sign below. I understand this child may be excluded from school for an extended period of time if there is an outbreak of one of the diseases for which required immunizations were declined. Printed name of parent/guardian _____

Signature of Parent/Guardian _____ Date of Signature _____

Physician/ PA/ APN/ CNP to complete

Health history, limitations, restrictions, special needs for learning/school environment:

The above named child has been examined, the immunization status has been recorded and the child is in suitable condition for participation in group care.

Examining Physician/ Physician's Assistant/ Advanced Practice Nurse/ Certified Nurse Practitioner

Signature _____ Date _____

Printed Name: _____

Address: _____

Phone: _____

Date of Exam: _____

Bellevue City Schools

PRESCHOOL REGISTRATION FORM

Please complete ALL sections			Date of Application	
Legal Last Name	First	Middle	Suffix	Grade
Address		City	Zip	
EMS ID (Office Use Only)		Phone: <input type="checkbox"/> unlisted	Cell:	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	City of Birth	County of Residence	

Ethnicity: Is this student Hispanic/Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes, Hispanic/Latino	(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other:
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Race: Regardless of what you selected above, please continue to answer the following by marking one or more of the boxes you consider your child's race to be:

- A** Asian (Origins in any of the original peoples of the Far East or the Indian subcontinent)
- B** Black or African American (Origin in any of the black racial groups of Africa)
- I** American Indian or Alaskan Native (Origin in any of the original people of North/South America, including Central America)
- P** Native Hawaiian or Pacific Islander (Origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands)
- W** White (Origins in any of the original peoples of Europe, North Africa, or the Middle East)

Father's information (do not list step-father)

Name:			
Address:			
City	State:	Zip:	Phone
Cell Phone:		Email Address	
Work Phone:		Place of Employment:	

Mother's Information (do not list step-mother)

Name:	Maiden Name:		
Address:			
City	State:	Zip:	Phone
Cell Phone:		Email Address	
Work Phone:		Place of Employment:	

Legal Guardian (if other than parents listed above) attach legal documentation

Name:	Maiden Name:		
Address:			
City	State:	Zip:	Phone
Cell Phone:		Email Address	
Work Phone:		Place of Employment:	

Marital Status of Parents: Married Single Separated Divorced Remarried Widowed Never Married

Student resides with: Biological/Adoptive Parents Mother only Father only Grandparents
 Mother/Stepfather Father/Stepmother Foster Family Other:

If parents are divorced or legally separated who is custodial parent? Please circle Father Mother Joint Custody

SIBLINGS

Name:	Age	Name	Age
Name:	Age	Name	Age

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

How do I apply for Early Childhood Education Services?

You will need to:

1. Complete the screening tool.
2. Do not submit to the Ohio Department of Education.
3. Submit this form to your provider.

How do I apply for Publicly Funded Child Care?

You will need to:

1. Complete the screening tool, JFS 01121.
2. Complete the JFS 01122 Publicly Funded Child Care Supplemental Application.
3. Submit both the JFS 01121 and JFS 01122 to your local county agency.
4. Attach verifications to the JFS 01122 (see verification requirements below).

How do I complete this application?

1. **Fill out this application:** Answer as many questions as you can.
2. **Be sure to sign the application.**

When will I receive assistance?

ECC: You will be notified by your provider when you may begin care.

Child care: Eligibility for the child care program is based on the date a signed application is submitted to the county agency. Eligibility for this program is determined within 30 days from the earliest date either the JFS 01121 or JFS 01122 is submitted.

What verifications do I need for publicly funded child care?

You will need to:

1. **Submit the JFS 01121 and JFS 01122.**
2. **Provide proof of income:** Verification of all money coming into your household. (such as pay stubs, tax records, award letters, child support)
3. **Proof of any child support paid.**
4. **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.
5. **Provide 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.
6. **Provide the name and address of an eligible child care provider chosen for each child in need of care.**

What is Step Up To Quality?

Step Up To Quality was created to help families identify early learning and development programs that go beyond the minimum standards of licensing. Star Rated programs demonstrate higher levels of quality in a variety of ways. Ask your provider if they are participating.

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

*This form is valid only for publicly funded child care when attached to a
JFS 01122 Publicly Funded Child Care Supplemental Application

Tell us about you (the applicant)

First Name	Middle Initial	Last Name		
Address				Today's Date
City	State	County		Zip Code
Phone Number ()	Additional Phone Number ()	E-mail Address		

Tell us about the people in your home

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

Tell us about your needs for your child(ren)

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

Tell us about your finances

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

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

If yes, please complete the table below.

Name	Type of Income	Amount of Income <i>(before taxes)</i>	How Often Received <i>(weekly, bi-weekly, etc)</i>	Date Last Received	Work or School Schedule <i>(please list times)</i>
					<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 Job and Family Services
PUBLICLY FUNDED CHILD CARE SUPPLEMENTAL APPLICATION

*This form is valid only for publicly funded child care when attached to a
 JFS 01121 Early Childhood Education Eligibility Screening Tool

1. Voter registration application attached - Assistance Available

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

YES, I want to register to vote. NO, I do not want to register to vote.

**If you do not check either box, you will be considered to have
 decided not to register to vote at this time.**

2. Applicant

First Name	Middle Initial	Last Name	Date of Birth
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3. Tell us more about you (the applicant)

Are you: <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired	Do you need any of the following services? <input type="checkbox"/> Interpreter <input type="checkbox"/> Sign Language <input type="checkbox"/> Other: _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Not married
--	---	--

Have you, or anyone living with you, ever received cash, child care, food, or medical assistance? Yes No

If yes, who: _____ Where (City/County/State): _____

What is your preferred language?

Spoken _____ Written _____

Do you and the people in your home have more than one million total dollars in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)? Yes No

Have you ever been found guilty of child care fraud? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have an Ohio Works First (OWF) Self-Sufficiency Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If you are a minor, are you currently in LEAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any college credit hours? <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____
---	--

Is anyone in your household in the military? Yes No

Active Duty National Guard/Reserve

4. Tell us how to reach you

Complete this section for the applicant

Mailing Address Check here if you are homeless

Street Address _____

City	County	State	Zip Code
------	--------	-------	----------

Phone Number ()	Additional Phone Number ()	E-mail Address
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5. Emergency Contact

First Name	MI	Last Name	<input type="checkbox"/> Not Applicable
------------	----	-----------	---

Street Address _____

City	County	State	Zip Code
------	--------	-------	----------

Phone Number ()	Additional Phone Number ()	E-mail Address
------------------------	-----------------------------------	----------------

6. Tell us about the people in your home who do not need care

You must list everyone who lives with you even if they are not applying. Please be sure to list your name first. If you need more space, attach a separate piece of paper.

Name (First, Middle, Last)	Social Security Number (optional)	Date of Birth	Highest Level of Education Completed	If currently enrolled in school, name of School/Program	Relationship to Child Needing Care (mother, father, grandparent, sibling, etc.)
			<input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> 2 Year Degree <input type="checkbox"/> 4 Year Degree Graduation date: _____	<input type="checkbox"/> High school <input type="checkbox"/> Vocational <input type="checkbox"/> College Name of School _____ Number of Credit Hours	SELF
			<input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> 2 Year Degree <input type="checkbox"/> 4 Year Degree Graduation date: _____	<input type="checkbox"/> High school <input type="checkbox"/> Vocational <input type="checkbox"/> College Name of School _____ Number of Credit Hours	
			<input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> 2 Year Degree <input type="checkbox"/> 4 Year Degree Graduation date: _____	<input type="checkbox"/> High school <input type="checkbox"/> Vocational <input type="checkbox"/> College Name of School _____ Number of Credit Hours	
			<input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> 2 Year Degree <input type="checkbox"/> 4 Year Degree Graduation date: _____	<input type="checkbox"/> High school <input type="checkbox"/> Vocational <input type="checkbox"/> College Name of School _____ Number of Credit Hours	
			<input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> 2 Year Degree <input type="checkbox"/> 4 Year Degree Graduation date: _____	<input type="checkbox"/> High school <input type="checkbox"/> Vocational <input type="checkbox"/> College Name of School _____ Number of Credit Hours	

7. Tell us about your child(ren) who needs child care

Child 1			
Name	Social Security Number <i>(optional)</i>	Child's Needs	School Questions
		Does child require protective child care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is there a case plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Entering Kindergarten: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Full Day Current grade Level _____ Time school in session _____ School Year Start Date: _____ End Date: _____ Name of School: _____ Is child in Head Start <input type="checkbox"/> Yes <input type="checkbox"/> No
Child 2			
Name	Social Security Number <i>(optional)</i>	Child's Needs	School Questions
		Does child require protective child care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is there a case plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Entering Kindergarten: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Full Day Current grade Level _____ Time school in session _____ School Year Start Date: _____ End Date: _____ Name of School: _____ Is child in Head Start <input type="checkbox"/> Yes <input type="checkbox"/> No
Child 3			
Name	Social Security Number <i>(optional)</i>	Child's Needs	School Questions
		Does child require protective child care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is there a case plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Entering Kindergarten: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Full Day Current grade Level _____ Time school in session _____ School Year Start Date: _____ End Date: _____ Name of School: _____ Is child in Head Start <input type="checkbox"/> Yes <input type="checkbox"/> No

8. Signature of person who completed this application

RIGHTS AND RESPONSIBILITIES FOR CHILD CARE BENEFITS

If an applicant is working, in training or in school, they may be able to have part of their child care costs paid by the Ohio Department of Job and Family Services (ODJFS). Eligibility will be based on monthly gross income and family size. The applicant may have to pay part of the cost of the child care. If approved, information will be loaded onto an Ohio Electronic Child Care (Ohio ECC) card. The applicant will be required to use this card to track a child's daily attendance. The child care provider or their designee shall not keep or use the card. If a swipe card is lost or stolen, a caretaker shall request a replacement swipe card within seven business days from the date of the last swipe.

Please complete this supplemental application along with the JFS 01121 and include proof of ALL sources of income for ALL members of the household. This includes earnings from jobs, tips, bonuses, retirement benefits, disability benefits, unemployment benefits, dividends, child/spousal/medical support, Ohio Works First (OWF) benefits and income from self-employment. A school schedule and transcripts for an education activity must also be provided if applicable. A need for child care for the days and hours of work, training or education activity must be shown. This application must be signed and dated.

Eligibility for child care benefits will be determined after this form and the JFS 01121 are completed and submitted to the county agency in the county where the applicant lives. If this application is approved and the applicant is eligible for child care benefits, the county agency may authorize payment for child care services from the date the county agency received the completed application. If the application is denied, the applicant may be responsible for payments to any child care provider whose services have been used since the submission of the application.

The applicant will be able to use child care only for children who are eligible and only up to the maximum hours authorized by the county agency for employment/training/education with allowances for travel time and other circumstances approved by the county agency. To remain eligible for child care, the required copayment must be paid, if applicable, to the provider. Failure to pay the applicable copayment may result in termination of child care benefits.

Any change, which affects child care eligibility, must be reported to the county agency including a change in family income, a change in hours of employment/training/education, a change in family size, and a change of address. **Changes must be reported within 10 days of the date the change occurs.**

I understand that this application will be considered without regard to race, color, ancestry, sex, age, handicap, religion or national origin. To the best of my knowledge and belief, the answers on this application are complete and correct. I understand that the law provides penalty of fine or imprisonment, or both, for anyone convicted of accepting assistance for which he or she is not eligible. I state under penalty of perjury that all information is true and complete to the best of my knowledge.

ASSURANCES

By signing and submitting the application, I acknowledge and agree that the county agency and the ODJFS may share certain details about the status of my application with the child care provider(s) listed in Section 7 of this application and any amendment thereto, as well as to any child care provider who I authorize to receive information regarding my application.

My signature below gives my consent to the agency and the ODJFS to make contacts that are necessary to determine my eligibility for assistance and to verify the information I have given in this application. I understand that my signature below gives the county agency permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child / spousal / medical support income. My signature also gives consent to issue a system generated statewide student identifier (SSID) for each child listed in Section 7 of this application.

My signature below gives my consent and authorizes the county agency to access CRIS-E or Ohio Benefits Worker Portal for the purpose of verifying the citizenship status of the children in this case and for verification of the receipt of additional public assistance. I may revoke this authorization at any time by notifying the county agency in writing.

I have received an explanation regarding the requirements for determining eligibility, the reasons why I may not be eligible, my right to a state hearing, my responsibility for reporting changes to the county agency and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification of information or misuse of child care benefits, including misuse of the swipe card issued to me for the purpose of reporting children's daily attendance at a child care provider. If a swipe card is lost or stolen, I understand that I shall request a replacement swipe card within seven business days from the date of the last swipe.

I understand that I must use my Ohio electronic child care swipe card to record attendance at my child care provider(s) and that I may not give my card to my provider(s) or allow my provider(s) to use my swipe card.

I understand that if my child attends a Step Up To Quality program, if an assessment is completed on my child, the data will be collected and reported to ODJFS.

Child care fraud is the willful withholding or falsification of information or misuse of child care services as determined by a court of law. Failure to meet this reporting requirement may be considered fraud and may result in the following: 1) repayment of child care benefits which you received but for which you were not eligible; 2) termination or denial of child care benefits; or 3) penalty of fine and/or imprisonment if convicted of fraudulently receiving child care benefits for which you were not eligible.

Signature of Applicant	Signature of person who helped you complete this application (if applicable)	Date
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Your civil rights

Federal law and the policies of the U.S. Department of Health and Human Services (HHS) and the Ohio Department of Job and Family Services (ODJFS) and the local County Department of Job & Family Services (CDJFS) say that we must not discriminate on the basis of race, color, national origin, sex, age, or disability. To file a discrimination complaint, write or call HHS or ODJFS. HHS, and ODJFS are equal opportunity providers and employers.

Write or Call:

HHS

Region V, Office of Civil Rights
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601
(312)886-2359 (voice)
(312) 353-5693 (TDD) (312)886-1807 (fax)

Write or Call:

ODJFS

Bureau of Civil Rights
30 E. Broad St., 37th Floor
Columbus, OH 43215
(614) 644-2703 (voice)
1-866-227-6353 (toll free) (614) 752-6381 (fax) 1-866-221-6700 (TTY)

EXPLANATION OF STATE HEARING PROCEDURES

What is a state hearing?

If you think there has been a mistake or delay on your child care case, you may ask for a hearing by either the local county department of Job and Family Services (CDJFS) or the state department of Job and Family Services (ODJFS).

A state hearing is a meeting with you, someone from the CDJFS and a hearing officer from ODJFS. The person from the CDJFS will explain the action it has taken or wants to take on your case. Then you will have a chance to tell why you think it is wrong. The hearing officer will listen to you and to the CDJFS and may ask questions to help bring out all the facts. The hearing officer will review the facts presented and recommend a decision based on whether or not the child care rules were correctly applied in your case.

How do I ask for a hearing?

To ask for a hearing, call or write your CDJFS or write to ODJFS, Bureau of State Hearings, PO Box 182825, Columbus, Ohio 43218-2825. If you receive a notice denying, reducing or stopping your child care, fill out that form and mail it to the Bureau of State Hearings. You may also fax your hearing request to (614) 728-9574. ODJFS must receive your hearing request within 90 days of the mailing date of the notice of action. If someone else makes a written request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a hearing request by telephone.

How do I request a telephone hearing?

If you cannot attend the hearing at the scheduled location because you do not have transportation or child care or you have medical limitations, etc., you can call 1-866-635-3748 and participate by telephone. If you participate by telephone the hearing officer will call you on the day at the scheduled time for your hearing at the telephone number you provide.

Will my child care benefits continue?

If you receive a notice that your child care will be reduced, stopped or restricted, the action will not be taken until the hearing is decided if we receive your hearing request within the 15 days of the mailing date on the notice.

If your child care benefits have been changed without written notice or if the change was made even though you requested a timely hearing, you can call the Bureau of State Hearings to ask if you should receive continuing benefits. Call 1-866-635-3748 and choose option number 1 from the automated voice menu. If your assistance is continuing and you lose the hearing, you may have to pay back any benefits that you were not eligible to receive.

What is a county conference?

An informal meeting with a person from the CDJFS may settle the issue without the need for a state hearing. This is often the quickest way to solve a problem. At this meeting someone will review your case with you. If a mistake was made, it can be corrected without the need for a state hearing. You can set up a county conference by asking your worker. If you are not satisfied with the results you can still have a state hearing. You do not have to have a county conference to have a state hearing and asking for a county conference will not delay your state hearing.

When will the hearing be held?

The Bureau of State Hearings will send you a notice giving the date, time and place of the hearing. This notice will be sent to you at least 10 days before the hearing. The notice also will tell you what to do if you cannot come to the hearing as scheduled. Hearings are usually held at the CDJFS. If you are unable to go there, the hearing may be held some other place convenient to you and to the other people involved. If you want the hearing held somewhere other than the CDJFS, be sure to state that on your hearing request.

Can a hearing be postponed?

If you cannot come to the hearing as scheduled or if you need more time to prepare, you can ask for a postponement. You must have a good reason to postpone the hearing.

What happens if I do not attend the hearing?

The Bureau of State Hearings will send you a dismissal notice if you don't come to the hearing. If you want to continue with your hearing request, you must contact State Hearings within 10 days and explain why you did not come to the hearing. The hearing authority will decide whether you had a good reason. If you do not call within 10 days and show good cause, the hearing will be dismissed and you will lose the hearing. The CDJFS can then take the action it was planning to take. If you disagree with the dismissal, the dismissal notice will tell you how to ask for an administrative appeal.

What happens before the hearing?

You may have someone (lawyer, welfare rights person, friend or relative) go to the hearing to present your case for you. If you are not going to be at the hearing, the person attending for you must bring a written statement from you saying he or she is your representative. If you want legal help at the hearing, you must make arrangements before the hearing. Contact your local Legal Aid program to see if you qualify for free help. If you don't know how to reach your Legal Aid, call 1-800-589-5888 (toll-free). If you want notice of the hearing sent to your lawyer, you must give the lawyer's name and address to the hearing authority. You and your representative have the right to look at your case file and the written rules being applied to your case. You can get a free copy of any case record documents that are related to your hearing request. Any person acting for you must provide a signed statement from you before looking at your case record or getting copies of case record documents. The CDJFS does not have to show you confidential records such as names of people who have given information against you, records of criminal proceedings and certain medical records. Confidential records, which you could not look at or question, cannot be presented at the hearing or be used by the hearing officer in reaching a decision.

Can I subpoena information?

You can ask the hearing authority to subpoena documents or witnesses that would not otherwise be available and that are essential to your case. You must request the subpoena at least five calendar days before the date of the hearing and provide the name and the address of the person or document you want subpoenaed.

What happens at the hearing?

You may bring witnesses, friends, relatives or your lawyer to help present your case. The hearing officer may limit the number of witnesses allowed in the hearing at any one time if there is not enough room. You and your representative will have the right to look at the evidence used at the hearing, present your side of the case without undue interference, ask questions and bring papers or other evidence to support your case. The hearing will be recorded by the hearing officer so that the facts are taken down correctly. The hearing officer will listen to both sides but will not make a decision at the hearing. Instead, you will receive a written decision in the mail, issued by the hearing authority. After the hearing decision is issued you can get a free copy of the recording by contacting the Bureau of State Hearings.

What is a group hearing?

The hearings office may combine several individual hearing requests into a single group hearing, but only if there is no disagreement about the facts of each case and all involve related issues of state or federal law or county policy. The notice to schedule your hearing will tell you if you are scheduled for a group hearing. You and your representative will be allowed to present your own case individually and you will have the same rights at a group hearing as you would at an individual hearing.

What happens after the hearing?

You should receive a hearing decision within 90 days of your hearing request. If you disagree with the hearing decision your written decision will tell you how to ask for an administrative appeal.

When will compliance with the hearing decision happen?

The CDJFS must take the action ordered by the decision within 15 days of the date the decision is issued but always within 90 days of your hearing request. Contact the Bureau of State Hearings if you have not promptly received the benefits awarded by the hearing decision.

Does another action require another hearing?

If you receive another notice that says the CDJFS wants to change your child care benefits while you are waiting for a hearing or decision, you must ask for another hearing if you disagree with the new action. Remember, the fact that you are waiting for a hearing or decision will not stop another action from being taken on your case. You must ask for another hearing on the new action.

=Voter Registration and Information Update Form=

Please read instructions carefully. Please type or print clearly with blue or black ink.
For further information, you may consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call (877) 767-6446.

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be *received or postmarked* by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Numbers 1 and 2 below are required by law. You *must* answer *both* of the questions for your registration to be processed.

Registering in Person

If you have a current valid Ohio driver's license, you must provide that number on line 10. If you do not have an Ohio driver's license, you must provide the *last four digits* of your Social Security number on line 10. If you have neither, please write "None."

Please see information on back of this form to learn how to obtain an absentee ballot.

Registering by Mail

If you register by mail and do not provide either an Ohio driver's license number or the last four digits of your Social Security number, you must enclose with your application a copy of one of the following forms of identification:

Current and valid photo identification, a military identification, or a current (within the last 12 months) utility bill, bank statement, government check, paycheck, or government document (other than a notice of voter registration mailed by a board of elections) that shows the voter's name and current address.

Residency Requirements

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

Your Signature

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

FOLD HERE

I am: Registering as an Ohio voter Updating my address Updating my name

1. Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Will you be at least 18 years of age on or before the next general election? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered NO to either of the questions, do not complete this form.	

3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.
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4. House Number and Street (Enter new address if changed)	Apt. or Lot #	5. City or Post Office	6. ZIP Code
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7. Additional Mailing Address (if necessary)	8. County (where you live)	FOR BOARD USE ONLY SEC4010 (Rev. 4/15)
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9. Birthdate (MO-DAY-YR) (required)	10. Ohio Driver's License No. OR Last Four Digits of Social Security No. (one form of ID required to be listed or provided)	11. Phone No. (voluntary)
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12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street			City, Village, Twp.
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Previous City or Post Office	County	State	Ward
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13. CHANGE OF NAME ONLY Former Legal Name	Former Signature	Precinct
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14. I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.	Your Signature ↓	Date _____ / _____ / _____ MO DAY YR	School Dist. Cong. Dist. Senate Dist. House Dist.
<div style="border: 1px dashed black; height: 60px; width: 100%;"></div>			

To ensure your information is updated, please do the following:

1. Print this form.
2. Complete all required fields.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections. For your county board's address please visit www.OhioSecretaryofState.gov/boards.htm.

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (877-767-6446).

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: www.OhioSecretaryofState.gov or by calling (877) 767-6446.

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring identification to the polls in order to verify identity. Identification may include current and valid photo identification, a military identification, or a copy of a current (within the last 12 months) utility bill, bank statement, government check, paycheck, or other government document (other than a notice of voter registration mailed by a board of elections) that shows the voter's name and current address. Voters who do not provide one of these documents will still be able to vote by providing the last four digits of the voter's Social Security number and by casting a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: www.OhioSecretaryofState.gov or call (877) 767-6446.

**WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY
OF A FELONY OF THE FIFTH DEGREE.**