



2009-2010 Child Eligibility Cover Sheet

- 2009-2010 Parental Choice Form**
Must be filled out completely and signed.
- 2009-2010 NSECD-EZ Form (Modified TANF-EZ)**
Must be filled out completely and signed by school official. Submit both front and back.
- Birth Certificate**
The child must be 4 years old and his/her birth must fall on or before September 30, 2009. (Eligible dates are: October 1, 2004 - September 30, 2005)
- Immunization Record** **Record Not Up To Date (30 Days For Updates)**
The child must have all age appropriate immunizations and a copy of the Up-to-Date Record from the LINKS Website must be submitted with this application.
- Proof of Residence**
*Verification can include a Louisiana **driver's license or current utility bill with the parents name and address**. If parent and child live with a family member or friend, that person is to provide their proof of residence with a letter. Child must be a resident of Louisiana.*
- Proof of Income**
At least one of the following: 2 current pay stubs, a letter from Employer, proof of Medicaid, proof of Food Stamps or proof of Social Security benefits.
- Child's Social Security Card**
A clear copy of the child's social security card or a letter from the social security office with both the child's name and social security number listed.
- 2009-2010 Intake Form**
Must be filled out completely and signed by the child's parent/guardian.

(Child's Name)

(School's Name)

**NO FAXES WILL BE ACCEPTED
ALL ORIGINAL APPLICATIONS ARE TO BE MAILED TO THE NSECD OFFICE.**

For NSECD Office Use

Date: _____

Status: _____

Reviewed By: _____

Class/Teacher: _____

Please Note:

- *All packets must be complete before submitting to the NSECD Office.*
- *A packet with missing information will not be eligible for the lottery.*
- *Schools must keep a copy of all submitted documentation on file.*



2009-2010 Parental Choice Certification

By signing below, I understand and agree to all of the following:

1. That my child is eligible for the Nonpublic Schools Early Childhood Development Program ("NSECDC") because he or she meets the eligibility requirements listed in Part 1 of the NSECDC Eligibility & Enrollment Procedures and Provider Responsibilities.
2. That in the event that more children apply than are accepted, a lottery will be held and my child's odds of being selected will be increased based on the number of schools I have applied to.
3. That I know and understand the mission, purpose, and curriculum of the school I have chosen and voluntarily choose to have my child go to school there as part of the NSECDC program.
4. That I give permission for NSECDC program officials to collect and utilize any of my child's test data and information during his or her school years to evaluate the efficacy of the program, deliver support services, and for other lawful purposes.
5. That the school I have chosen must agree to provide **high-quality, developmentally appropriate early childhood development classes** under the terms and conditions listed in the NSECDC Eligibility & Enrollment Procedures and Provider Responsibilities in order to be eligible to participate in the NSECDC program and to receive reimbursement for teaching my child, and that the school I have chosen will not be eligible for this payment if it fails to meet the requirements listed in the NSECDC Eligibility & Enrollment Procedures and Provider Responsibilities, including minimum teacher requirements.
6. That I will ensure that my child regularly attends 74% of classes and regularly arrives on time, during the school year, and must attend four (4) instructional hours on a given school day, in order for my child to be credited for attending a school.
7. That the school I have chosen will receive payment on my behalf of my child, from the Governor's Office of Community Program, and if my child does not attend classes regularly enough for the school to be reimbursed for two consecutive months, my child will be removed from the NSECDC Program, and the school will receive no payment for any educational services delivered to my child during this time period.
8. That it is my responsibility, to apply to the Free and Reduced Meal Program offered by the school, and if my child does not qualify for the Free and Reduced Meal Program, it is my responsibility to pay the cafeteria fee. I further understand that my child may be disenrolled if there is an outstanding balance for three (3) months.

Name of Child: _____ School Chosen: _____

Signature of Parent/Guardian: _____ Printed Name: _____

Address: _____

Contact #: _____

NSECDC Transfer (name of current NSECDC school) _____

*****NSECDC Program funding is subject to legislative approval*****



2009-2010 NSECD-EZ Eligibility Form for TANF-Funded Services

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Section I: Child's Identifying Information

Name: _____ Date of Birth: ___/___/20___

Address: _____ City: _____ Zip: _____

Phone Number: (____) _____ SSN: _____ Family Size: _____

Indicate Proof of Income Included with Application:

- Medicaid
- Food Stamps
- Social Security
- Check Stub
- Other: _____

Section II: Eligibility Criteria

I certify that the information, provided on this form, is true and correct to the best of my knowledge. If the information changes, I will notify a program staff person of the new information.

Signature of Parent/Guardian

Date signed

**TO BE COMPLETED BY PROVIDER STAFF TO DETERMINE
ELIGIBILITY FOR TANF FUNDED SERVICES**

Section III: TANF Service Goal

The services being provided are designed to:

- 1. Provide services to needy families so that the child or children may be cared for in their own home or the home of relatives.
- 2. Promote job preparation, work or marriage.
- 3. Prevent or reduce the incidence of out-of-wedlock pregnancies.
- 4. Encourage the formation and maintenance of two-parent families.

Section II: Eligibility Information. Eligibility is based on the following:

Directions for School Staff: Please check the appropriate boxes for the following 4 steps.

Step 1: The parent/guardian has provided a letter of eligibility or other official documentation to verify receipt of one or more of these services:

- Medicaid
- Food Stamps
- Social Security
- Other: _____

Step 2: The family income is less than 200% of the federal poverty level.

- Parent/guardian has submitted at least 2 current consecutive check stubs to verify income.
- Letter from his/her employer to verify rate of pay

Step 3: The family applying for services includes:

- A parent or relative caring for one or more children under 19 years of age (individual should provide documentation of their parental status); **or,**
- A pregnant woman; **or**
- A non-custodial parent of a child under 19 years of age.

Step 4: The TANF-funded services are for the benefit of a family member who is:

- A citizen of the United States; **or** A non-citizen who meets the TANF-eligible citizen criteria

I certify that the information, provided on this form has been completed by the parent/guardian, is true and correct to the best of my knowledge. I understand that all supporting documentation required, must be attached to this form before submitting to the NSECD Office. If any information changes, I will notify the NSECD Office staff and submit new information if needed.

Signature of School Staff

Date signed

Signature of NSECD Office

Date signed

Proof of Income Eligibility is based on the following:

Your child is automatically qualified if you receive one of the following:

- Medicaid
- Food Stamps
- Social Security

If you do not receive any of the items listed above, you must submit one of the following:

- Two (2) consecutive check stubs for the current year (within 2 months from the date you are filling out this application)
- An official letter from your employer stating
 - (1) Where you are employed
 - (2) Your hourly rate of pay
 - (3) The average number of hours you work per week.

When a paycheck stub or a letter from your employer is submitted, your income eligibility is calculated by the following:

**NSCED Worksheet on Family Income
Eligibility for TANF-Funded Services
(Current as of 5.4.09)**

Countable Income Limits: 200% FPL		
Family Size	Gross Annual Income*	Gross Monthly Income*
1	21,660.00	1,805.00
2	29,140.00	2,428.33
3	36,620.00	3,051.67
4	44,100.00	3,675.00
5	51,580.00	4,298.33
6	59,060.00	4,921.67

Monthly Income Calculation Table: How to Translate Income into a Monthly Figure	
Pay Period	Formula
Monthly, <i>same gross pay each month</i>	Use gross salary
Monthly, <i>gross pay differs each month</i>	Total gross salary from consecutive months ÷ appropriate number of months (e.g., Gross salary of last 2 months ÷ 2, or Year To Date gross salary as of June 30 ÷ 6 Months)
Paid exactly 2 times per month (e.g., 1 st and 15 th of each month)	Gross salary x 2
Paid Every 2 weeks	Gross salary ÷ 2 x 4.33
Weekly	Gross salary x 4.33
Hourly	Hourly wage x hours per week x 4.33

**Louisiana Department of Social Services
 Consent to Release Information (Other than Protected Health Information)
 Waiver of Confidentiality Form**

All information that has been gathered on an individual is personal and private, and you are not required to release this information. Such information cannot be released without authorized written permission, except as required by law.

1. Client Name:	Date of Birth:
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Mailing Address:

City/State/Zip Code:

I give my permission for:

2. Name:
 Department of Social Services/Office of Family Support

Mailing Address:
 627 N. Fourth Street

City/State/Zip Code: Baton Rouge, LA 70802	Telephone Number: (225) 342-2342
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To release information to:

3. Name:
 NSECD Program

Mailing Address:
 150 Third Street

City/State/Zip Code: Baton Rouge, LA 70801	Telephone Number: (225) 342-0425
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**4. The following specific information:
 verify as a recipient of food stamps**

**5. The above-listed information is to be released for the specific purpose of:
 eligibility for enrollment in the NSECD state Pre-k Program**

6. I understand that my permission to release this information may be cancelled at any time except when the information has already been released. My permission to release this information will expire on

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Signature of Client	Date
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Signature of Witness	Date
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7. The undersigned certifies that he/she is the parent/guardian/representative of the person listed above in Item 1, and has the legal authorization to sign on behalf of the person, whether by court order or operation of law.

Signature of Parent, Guardian, or Custodial Agency	Date
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Signature of Witness	Date
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2009-2010 NSECD Intake Form

(Complete only for children funded through NSECD)

Confidential: All information that would identify any individual will be held strictly confidential.
Instructions: Please complete all of the requested information for the items listed below.

- A. **Child Identification** (If both the social security (SSN) and state identification number are available, please provide the SSN).

FIRST NAME _____ **MI** _____ **LAST NAME** _____

Date of Birth ____/____/____ **SSN OR STATE ID NUMBER:** ____-____-____

Race: (Check one)

- | | |
|--|---|
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Haitian |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Native Hawaiian and Other Pacific Islander |
| <input type="checkbox"/> White | <input type="checkbox"/> Other Race |
| <input type="checkbox"/> American Indian & Alaska Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Two or more races | <input type="checkbox"/> Unknown |

Gender: (Check one) Male Female

Language: _____ (Child's Primary Language)

Disability: (Only Check Identified Disabilities otherwise check None)

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Suspect | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Orthopedic Impairment | <input type="checkbox"/> Multiple Disabilities |
| <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Other Health Impairment |
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Specific Learning Disability |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Language Impairment | <input type="checkbox"/> ADHD |
| | <input type="checkbox"/> Other State Definition |

- B. **Test Administrator's Name:** _____

MM/DD/YY

- C. **Entry Date:** ____/____/____

- D. **Child's Educational Classification (Select One)**

Regular Education Special Education (not Gifted or Talented) Gifted; Talented

- E. **Before age 3, did the child receive special services for a special need through Part C or CHILDNET (Early Steps), such as Speech/Language, Physical Therapy, Occupational Therapy, or Special Instruction?** Yes No

- F. **Is English the Primary Language Spoken at Home?** Yes No

G. Indicate the Current Annual Household Income in U.S. Dollars:

- Under \$10,000 \$ 20,000 - \$29,999 \$ 40,000 - \$49,999
 \$ 10,000 - \$ 19,999 \$ 30,000 - 39,999 \$ Over \$ 50,000

H. Does the Child Qualify for the Free/Reduced Lunch Program? (Select One)

- Yes, Free Lunch Yes, Reduced Lunch No

I. How many children under the age of 18 currently live in the child's household, including this child?

- 1 2 3 4 5 6 7 8 9 10 or more.

J. What is the Highest Grade in School that the Mother/Female Guardian Completed?

- | | |
|--|---|
| <input type="checkbox"/> No Father or Male Guardian | <input type="checkbox"/> Some Education after High School |
| <input type="checkbox"/> Below 6 th grade | <input type="checkbox"/> High School Graduate |
| <input type="checkbox"/> 7 th grade | <input type="checkbox"/> Some education after High School |
| <input type="checkbox"/> 8 th grade | <input type="checkbox"/> Associate or Vocational Degree |
| <input type="checkbox"/> 9 th grade | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> 10 th grade | <input type="checkbox"/> Some Education after College |
| <input type="checkbox"/> 11 th grade | <input type="checkbox"/> Graduate Degree |
| <input type="checkbox"/> 12 th grade | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> GED | <input type="checkbox"/> Other |

K. What is the Highest Grade in School that the Father/ Male Guardian Completed?

- | | |
|--|---|
| <input type="checkbox"/> No Father or Male Guardian | <input type="checkbox"/> Some Education after High School |
| <input type="checkbox"/> Below 6 th grade | <input type="checkbox"/> High School Graduate |
| <input type="checkbox"/> 7 th grade | <input type="checkbox"/> Some education after High School |
| <input type="checkbox"/> 8 th grade | <input type="checkbox"/> Associate or Vocational Degree |
| <input type="checkbox"/> 9 th grade | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> 10 th grade | <input type="checkbox"/> Some Education after College |
| <input type="checkbox"/> 11 th grade | <input type="checkbox"/> Graduate Degree |
| <input type="checkbox"/> 12 th grade | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> GED | <input type="checkbox"/> Other |

L. Was the Child in any type of Non Parental Care for a Period of 6 months or Longer before Entering the Pre-Kindergarten Program? Yes No

If yes, indicate type of child care used for 6 months or longer since birth:

- | | |
|---|--|
| <input type="checkbox"/> Child Care Center | <input type="checkbox"/> Registered family day care |
| <input type="checkbox"/> Care Center in a church | <input type="checkbox"/> At child's home with relative |
| <input type="checkbox"/> Early Head Start (for ages 0-2) | <input type="checkbox"/> At relative's home |
| <input type="checkbox"/> Head Start | <input type="checkbox"/> At neighbor's home |
| <input type="checkbox"/> At Child's home with paid babysitter | <input type="checkbox"/> Other (specify) |

Name of School: _____

Parent Signature: _____ Date: _____