

Academy School District 20

2020-2021 Colorado Preschool Program Application

Today's date _____

Child's Name: _____ Birth date: _____

Family Information (or custodial guardian)

Child lives with: _____ Relationship: _____

Name: _____

Address: _____

Length of time at address: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address _____

Graduated High School: Yes No

Age at birth of child: _____

Employer: _____ Phone: _____

Family Information 2 (or custodial guardian)

Name: _____ Relationship: _____

Address, if different: _____

Length of time at address: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Graduated High School: Yes No

Age at birth of child: _____

Employer: _____ Phone: _____

Information to help us get to know your child and family

These are things I want my child to learn in preschool this year:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

My child's favorite food is: _____

My child's favorite toy is: _____

My child is good at: _____

My child doesn't like these foods: _____

My child needs help with: _____

Names of brothers and sisters and ages: _____

Do you have previous or existing IFSP? _____ Yes _____ No

Please list all people who live in your home, including family members who were part of the household but are now deceased:

Last Name	First Name	Relationship to child	Date of Birth	Last Grade Completed	Deceased?

Describe your current living situation, including any recent changes: _____

Describe any disruptions or stresses your family is currently experiencing (frequent moves, illness, separations, etc.) or serious situations from your child and family's past: _____

Is your child adopted? ____ Yes ____ No If so, at what age _____

Comments _____

Is/Was your child in Foster care? ____ Yes ____ No If yes, please explain _____

Language

My child understands and speaks English well: Yes No

Primary language(s) spoken in the home: _____

I have concerns about my child's speech: Yes No

If yes, describe: _____

Other languages spoken in your home: _____

My signature indicates that the information I have provided in this application is true and that I agree to participate in my child's preschool education as described in the Family Involvement section.

Signature

Date

Feel free to include any additional information below or on the back of this form:

Health History

Child's Name: _____ Date Form Completed: _____

Current Health Status

How is your child's health now? Excellent Good Fair Poor

Explain any health problems or concerns: _____

Has your child ever seen a medical specialist? No Yes

Explain: _____

Does your child have a known medical diagnosis: No Yes

If yes, what is the diagnosis: _____

At what age was your child diagnosed? _____

Is your child on medication now? No Yes Medication Name: _____

When: _____ Dosage: _____

Date of last physical: _____ Primary Physician: _____

Physician Address: _____

Hospital of choice: _____

Are your child's shots up to date? Yes No - Reason: _____

Date of last vision test: _____ Where? _____ Results: _____

Does your child wear glasses or contact lenses? No Yes

Explain vision/eye problem(s) and when it started: _____

Did your baby pass his/her Newborn Hearing Screening? Yes No

Date of last hearing test: _____ Where? _____ Results: _____

Do you think your child may having a hearing problem? No Yes

If yes, explain: _____

Date of visit to dentist: _____ Dentist's Name: _____

Dentist's Address: _____

Medical History

Has your child had any of the following? Please check and comment on the lines below.

<input type="checkbox"/>	Upper respiratory infections	<input type="checkbox"/>	High fever	<input type="checkbox"/>	Sleeping problems
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Convulsions/seizure	<input type="checkbox"/>	Dental problems
<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Feeding/eating problems
<input type="checkbox"/>	Frequent sore throat	<input type="checkbox"/>	Heart problem/condition	<input type="checkbox"/>	Weight problems
<input type="checkbox"/>	Stomach aches	<input type="checkbox"/>	Social emotional problems	<input type="checkbox"/>	Hyperactive
<input type="checkbox"/>	Bladder control difficulty	<input type="checkbox"/>	Frequent nose bleeds	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Urinary tract infections	<input type="checkbox"/>	Minor/major surgery	<input type="checkbox"/>	Significant accident/injury
<input type="checkbox"/>	Head injury/concussions	<input type="checkbox"/>	Bone/orthopedic problems	<input type="checkbox"/>	Other:

If yes, explain: _____

Health History (cont.)

Nutrition

Describe what your child eats in a typical day: _____

Describe his/her eating habits: _____

Birth History

How far along was the mother when she found out she was pregnant? _____

Did the mother receive prenatal care? Yes No

Did the mother smoke or use alcohol during pregnancy? Yes No If yes, which one? _____

How often? _____

What drugs or medication were taken during pregnancy? _____

Did the mother have any illness or difficulties during the pregnancy? Yes No

Explain: _____

Length of pregnancy: _____ weeks, Length of labor: _____ hours, Child's birth weight: _____ lbs. _____ oz.

Labor was: Easy Normal Difficult Delivery was: Vaginal C-Section

Comments: _____

Any other complications at or right before birth? (Such as oxygen or blood transfusion needed for infant, etc.):

Early Development

As an infant, did/does your child have any difficulty with any of the following?

Feeding Allergies Colic Poor Weight Formula intolerance Sleeping

Explain: _____

Family Medical History

Is there a family history of any of the following? (Check all that apply and put the relationship of the person to the child)

<input type="checkbox"/>	Heart disease/problems - Relation:	<input type="checkbox"/>	Asthma - Relation:
<input type="checkbox"/>	Seizures/Epilepsy - Relation:	<input type="checkbox"/>	Diabetes - Relation:
<input type="checkbox"/>	TB - Relation:	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Neurological (nerve) disorders - Relation:	<input type="checkbox"/>	Explain:
<input type="checkbox"/>	Birth Defects - Relation:		

Is there anything else we should know about your child's health? _____

Social History

Child's Name: _____ Date Form Completed: _____

In the following area, indicate at what age your child accomplished the tasks/skills:

Task/skill	Age	Task/skill	Age
Turned over		Walked alone	
Smiled at parents		Fed self	
Sat alone		Said "no, no" to everything	
Crawled		Used phrases/sentences	
Said first word		Toilet trained	
Helped with dressing		Dressed alone	
Drank from a cup			

Additional comments on your child's development: _____

Please check those that describe your child:

<input type="checkbox"/>	Affectionate & loving	<input type="checkbox"/>	Rocks or spins	<input type="checkbox"/>	Demands constant attention	<input type="checkbox"/>	Has staring spells
<input type="checkbox"/>	Has temper tantrums	<input type="checkbox"/>	Impulsive	<input type="checkbox"/>	Well-coordinated	<input type="checkbox"/>	Avoids attention
<input type="checkbox"/>	Doesn't pay attention	<input type="checkbox"/>	Has fears	<input type="checkbox"/>	Difficulty taking turns	<input type="checkbox"/>	Curious
<input type="checkbox"/>	Has a sense of humor	<input type="checkbox"/>	Holds breath	<input type="checkbox"/>	Bangs head repeatedly	<input type="checkbox"/>	Clumsy
<input type="checkbox"/>	Has sleep problems	<input type="checkbox"/>	Creative	<input type="checkbox"/>	Shows daredevil behavior	<input type="checkbox"/>	Stubborn
<input type="checkbox"/>	Prefers to play alone	<input type="checkbox"/>	Falls often	<input type="checkbox"/>	Dislikes change in routine	<input type="checkbox"/>	Avoids eye contact
<input type="checkbox"/>	Spins, lines up toys	<input type="checkbox"/>	Shares toys	<input type="checkbox"/>	Licks or smells non-food items	<input type="checkbox"/>	Shy or timid

My child's strengths: _____

My child's developmental need: _____

My child enjoys: _____

My child is bothered by: _____

I am worried about: _____

Do you have concerns or questions regarding your child's behavior? Describe: _____

What activities does your family enjoy doing together? _____

Relatives or other important people who are a support to your family: _____

**Social History
(cont.)**

Professional/programs that have been helpful to your family or that you are currently involved with: _____

Immediate family history of any of the following or major changes (check all that apply):

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Drug dependence	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	Learning problem
<input type="checkbox"/>	Homelessness	<input type="checkbox"/>	Incarceration	<input type="checkbox"/>	Significant illness	<input type="checkbox"/>	Death in family
<input type="checkbox"/>	Divorce	<input type="checkbox"/>	New sibling	<input type="checkbox"/>	Custody arrangement	<input type="checkbox"/>	Parent currently deployed
<input type="checkbox"/>	Abuse						

Comments: _____

Community Resources

Please check all the community resources that your family currently uses or would be interested in getting more information:

Use	Info Needed	Community Resource
		TANF - Temporary Assistance for needy families
		DHS - Child Welfare/Protection
		Food stamps
		Health insurance - Medicaid, CHP+
		SSI - Supplemental Security Income
		Professional counseling or evaluation
		Child Care/Preschool
		Colorado Child Care Assistance Program
		Community Partnership for Child Development - Head Start/Early Head Start
		Pikes Peak Mental Health/Project Bloom
		CASA - Court Appointed Special Advocate
		GAL - Guardian Ad Litem
		TESSA (Domestic Violence Prevention)
		WIC - Women, Infants and Children
		Private therapy services:
		Military program:
		El Paso County Dept. of Health Program:
		Dental care for your child/family
		Health care for your child/family
		Recreational services
		Parenting resources

Person completing form

Date

**2020-2021 FAMILY ECONOMIC DATA SURVEY
FOR AT-RISK FUNDING ELIGIBILITY**

PARENT/GUARDIAN INSTRUCTIONS

This survey is used by the Academy School District 20 to maximize available funding from state and federal sources. In many cases, the eligibility for these funds and programs is linked to whether or not your child is currently eligible for free or reduced price meals in the federal child nutrition programs.

This application form will be used by the school district to determine whether the school is eligible for at-risk funding on behalf of the student. By filling out this form, parents are ensuring that the school district will receive the at-risk funding to which it is entitled based on the population of students serviced by the district.

Complete one survey per household.

INSTRUCTIONS FOR APPLYING

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP (SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM) OR FDPIR (FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS), FOLLOW THESE INSTRUCTIONS:

- Part 1:** List all students; indicate school and grade for each student.
- Part 2:** List the name of the household member receiving the benefit, and list the case number.
- Part 3:** Skip this part
- Part 4:** Skip this part
- Part 5:** If you do not want your information shared with Medicaid or SCHIP, check this box.
- Part 6:** Sign and date the form.

IF YOU ARE APPLYING FOR A MIGRANT, HOMELESS, OR RUNAWAY CHILD, FOLLOW THESE INSTRUCTIONS:

- Part 1:** List all students; indicate school and grade for each student. Indicate if the student is Homeless, Migrant or Runaway.
- Part 2:** Skip this part
- Part 3:** Call [school, homeless liaison or migrant coordinator]
- Part 4:** Skip this part
- Part 5:** If you do not want your information shared with Medicaid or SCHIP, check this box.
- Part 6:** Sign and date the form.

IF YOU ARE APPLYING FOR A FOSTER CHILD OR MULTIPLE FOSTER CHILDREN ONLY FOLLOW THESE INSTRUCTIONS:

- Part 1:** List all students; indicate school and grade for each student. Check the foster check box for each foster child.
- Part 2:** Skip this part
- Part 3:** Skip this part
- Part 4:** Skip this part
- Part 5:** If you do not want your information shared with Medicaid or SCHIP, check this box.
- Part 6:** Sign and date the form.

FOR ALL OTHER HOUSEHOLDS, INCLUDING WIC AND HOUSEHOLDS THAT HAVE FOSTER CHILD(REN) LIVING WITH THEM ALONG WITH NON-FOSTER CHILD(REN), FOLLOW THESE INSTRUCTIONS:

- Part 1:** List each child's name, school, and grade. If the child is a foster child, check the foster box. For all students listed, if **NO INCOME**, you must check the no income box.
- Part 2:** Skip this part.
- Part 3:** Skip this part.
- Part 4:** Follow these instructions to report all household income. Income can be from the previous month, this month, or your projected income for next month.
- Column 1–Name:** List the first and last name of each person living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children living with you not listed in Part 1 and students that have income. Attach another sheet of paper if you need to.

Column 2–Check if no income: If the person does not have any income, check the box.

Column 3–6 Gross income and how often it was received: Next to each person's name, list each type of income received and how often it was received.

Earnings from work: example: If you are paid \$500.00 bi-weekly, please record \$500.00 in the income blank and mark the bi-weekly check box. **Gross income is the amount earned before taxes and other deductions.**

Additional Income Sources: List the total amount each person received from **all other sources**. For example: If you receive \$500.00 monthly for child support, please record \$500.00 in the income blank and mark the monthly check box.

Other Income: Report net income for self-owned business, farm, or rental income. Next to the amount, check how often the person receives it. If you are in the Military Housing Privatization Initiative, do not include this housing allowance.

- Part 5:** If you do not want your information shared with Medicaid or SCHIP, check this box.
- Part 6:** An adult household member must sign and date the form.

INCOME TO REPORT:

Earnings from Work
Wages/salaries/tips
Strike benefits
Unemployment
Compensation
Worker's Compensation
Net income from self-owned business or farm

Welfare/Child Support/Alimony
Public assistance payments
Welfare payments
Alimony
Child support payments

Pensions/Retirement/Social Security/SSI/VA Benefits
Pensions
Supplemental Security Income
Retirement income
Veteran's benefits
Social Security

Other Income
Disability benefits
Cash withdrawn from savings
Interest/Dividends
Income from Estates/Trusts/Investments
Regular contributions from people not living in the household
Net royalties/annuities/net rental income
Any other income

2020-2021 Family Economic Data Survey

Last Name(s) of Family

Mailing Address, City, Zip Code

Telephone Number

INSTRUCTIONS: Using the instruction sheet provided, complete the application, sign your name, date, and return application to school.

Part 1. Student Information. List all students attending school in the district; provide school and grade information. Check the foster child check box for all students that are the legal responsibility of a welfare agency or court. **If the student has NO INCOME, you MUST check the No Income box.** If the student has income please add the student to the household section below and provide income information.

H: Homeless
M: Migrant
R: Runaway

Foster Child	Student Name: Last, First	School	Grade	No Income	H	M	R
<input type="checkbox"/>				<input type="checkbox"/>			
<input type="checkbox"/>				<input type="checkbox"/>			
<input type="checkbox"/>				<input type="checkbox"/>			
<input type="checkbox"/>				<input type="checkbox"/>			
<input type="checkbox"/>				<input type="checkbox"/>			
<input type="checkbox"/>				<input type="checkbox"/>			
<input type="checkbox"/>				<input type="checkbox"/>			
<input type="checkbox"/>				<input type="checkbox"/>			

Part 2. Supplemental Nutrition Assistance Program (SNAP) /Food Distribution Program on Indian Reservations (FDPIR):

Provide the name and case number for the person who receives benefits.

(Enter information and skip to part 5)
Name: _____

Case Number: _____

Part 3. Other Source Eligibility: If any child you are applying for is **HOMELESS, MIGRANT, OR RUNAWAY**, check the appropriate box to the left and call the homeless liaison at 719-234-1376.

Part 4. List all household members not listed above AND students with income. List all current gross income, and check how often it was received.

Name: Last, First	No Income	Earnings from work before deductions, or unemployment	Welfare, child support, alimony	Pensions, retirement, Social Security, SSI, VA benefits	Other
	<input type="checkbox"/>	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month
	<input type="checkbox"/>	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month
	<input type="checkbox"/>	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month
	<input type="checkbox"/>	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month
	<input type="checkbox"/>	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month
	<input type="checkbox"/>	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month
	<input type="checkbox"/>	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month	\$_____ <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly <input type="checkbox"/> weekly <input type="checkbox"/> 2x/month

Part 5. MEDICAID AND/OR STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

The information provided in the application may be shared with Medicaid or SCHIP offices to seek enrollment of children into the above programs. You are not required to consent to the disclosure of this information; this will not affect your student(s)' eligibility status. Your information MAY be shared unless you check the box below. Please do NOT share my information with the Medicaid or SCHIP offices.

Please do NOT share my information with the Medicaid or SCHIP offices.

Part 6. Signature: (Adult **MUST** sign and date)
An adult household member must sign and date the application.
I certify (promise) that all information on this application is true and that all income is reported. I understand that the school district may get funding based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose benefits, and I may be prosecuted. Sign here: X _____ Date: _____

*****DO NOT WRITE BELOW THIS LINE. DISTRICT USE ONLY*****

Annual Income Conversion: Weekly x 52; Bi-Weekly x 26; 2 Times per Month x 24; Monthly x 12

Total Income: _____ Per Week, Bi-Weekly, 2x/Month, Month, Year Household size: __ Eligibility: Free ___ Reduced: _____ Denied: _____
 Income Categorically Eligible App Num.: _____ Determining Official's Signature: _____ Date: _____ Withdrawn Date: _____