Academy School District 20
2021-2022 Colorado Preschool Program Application

Today's date_____

Child's Name: _____ Birth date:_____ Male _____ Female _____

Parent/Custodial Guardian #1 Information

Child lives with:_____ Relationship:_____

Name:_____

Address:_____ Zip Code _____

Neighborhood School _____

Length of time at address: _____

Home Phone:_____ Cell Phone:_____

E-Mail Address_____

Graduated High School: Yes No

Age at birth of child: _____

Employer:_____Phone:_____

Parent/Custodial Guardian #2 Information

Name:_____Relationship:_____

Address, if different:_____ Zip Code _____

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.

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

	Heart disease/problems - Relation:		Asthma – Relation:
	Seizures/Epilepsy – Relation:		Diabetes – Relation:
	TB – Relation:		Other:
	Neurological (nerve) disorders – Relation:		Explain:
	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:

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

	Alcoholism		Drug dependence		Mental illness		Learning problem
	Homelessness		Incarceration		Significant illness		Death in family
	Divorce		New sibling		Custody arrangement		Parent currently deployed
	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

2021-2022 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/ SocialSecurity/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

2021-2022 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
				☐			
				☐			
				☐			
				☐			
				☐			
				☐			
				☐			

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
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month
	☐	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 2x/month	$_____.__ ☐ monthly ☐ bi-weekly ☐ weekly ☐ 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 q Week, q Bi-Weekly, q 2x/Month, q Month, q Year Household size:______ Eligibility: Free___ Reduced:_________ Denied:_________

q Income q Categorically Eligible App Num.:_____________Determining Official's Signature:____ Date:___________Withdrawn Date:__________