Ohio Valley ESC
Bright Beginnings Preschool

NEW student

Enrollment Application

2025-2026 School Year

We are excited to learn with you!

This packet must be completed and all documentation submitted as soon as possible for your child to be considered for a classroom spot.

Questions?

email: joy.edgell@ovesc.org

Thank you for letting us serve your family!

★ *Application will require extra postage - please use 3 stamps when mailing.*

PRINT DOCUMENT 1 SIDED ONLY - NO double sided copies please!

revised:12/2024

Information:

Thank you for your interest in the Ohio Valley Educational Service Center's Bright Beginnings Preschool for students ages 3 through 5 years old. Children are placed in classes **once ALL required paperwork and documents are submitted.** We place returning students first, then we place by age of the child (older children are placed first), and last we place by the date of the returned, completed application. We look forward to working with your family!

COST:

Bright Beginnings Preschool offers payment options based upon income and the number of days your child attends class per week/month. **The tuition is a flat rate and refunds are NOT given for absences, holidays and/or calamity days.** The maximum tuition rate possible is $150.00 for full time enrollment per month. Tuition assistance may be available upon completion of the enrollment application and submission of required proof of income documents. Tuition is due prior to starting preschool and is due on the first day of each month. May's tuition is due April 15. Tuition may be paid at either OVESC office (Cambridge or Marietta), through USPS mail, or online at www.ovesc.org

REQUIRED DOCUMENTS FOR ADMISSION for ALL STUDENTS:

- Enrollment Application (with ALL SECTIONS completed, including the child care assistance pages)
- Child Care Assistance application filled in and (SNAP, MEDICAID, tax return or pay stubs submitted)
- Birth certificate (the actual copy, we can not accept the crib sheet from the hospital)
- Custody Papers (if applicable)
- Proof of Residency (a copy of a utility bill) and Proof of income
- Immunization Record

We also require a Valid EMAIL ADDRESS

→ *Please make sure to sign every signature line with an arrow beside it*

ALL REQUIRED INFORMATION IS MANDATORY to secure your child's spot in a preschool classroom.

Once our Marietta office receives your completed packet, we will notify you if there is an opening for your child.

Medical and Dental Forms(to be completed by a medical professional):

- Students have 30 days from classroom start date to submit both documents
- New forms must be submitted yearly (within 13 months of last visit due to insurance reasons)

MAIL TO:

OVESC BRIGHT BEGINNINGS PRESCHOOL
Broughtons Complex 3 - Building 16B
2333-B St. Rt 821
Marietta, Ohio 45750

Attention:
Due to a recent change after printing, we will need 4 current paystubs instead of 3.

Ohio Valley ESC
Bright Beginnings Preschool

Enrollment Application 25-26

My child is a **RETURNING STUDENT** or **NEW STUDENT** (please circle one)

CHILD'S NAME: (Please PRINT entire application)

First:	Middle:	Last:

Child's Information:

Date of Birth:	Gender (please circle): Male Female
Foster Child: ____ Yes ____ No	Primary Language Spoken at Home:
Birthplace City:	County of residence:
Mother's Maiden Name:	
Does your child have an IEP? **YES or NO**	Did your child attend Bright Beginnings Preschool previous school year? : ____ Yes ____ No

Racial Group/Local Ethnic Category: (check all that apply)

____ Asian ____ Black/African American ____ Hispanic
____American Indian/Alaska Native ____ Multi-Racial
____ White ____ Native Hawaiian or Other Pacific Islander

Hispanic/Latino: ____ Yes ____ No **Is the parent an OVESC employee? ____ Yes ____ No**

Who Child Lives with/Residential Parent is: (circle all that apply): Mother Father Other

Father's Name:	Mother's Name:
Father's Address:	Mother's Address:
City, State and zip	City, State, and zip
Father's Home #:	Mother's Home #:
Father's Cell #:	Mother's Cell #:
Father's Work #:	Mother's Work #:
Father's Email **(must have)**:	Mother's Email **(must have)**:
School District of Residence:	School District of Residence:

Preferred School – Please mark - 1st choice, 2nd choice, 3rd choice (Listed by District/School):

___ Belpre- Belpre
___ Fort Frye - Lowell
___ Fort Frye - Beverly-Center
___ Frontier - Newport
___ Marietta - Phillips
___ Marietta -Washington
___ Crooksville
___ Rolling Hills - Beechgrove
___ Switzerland of Ohio - Beallsville
___ Switzerland of Ohio - Powhatan
___ Switzerland of Ohio - River
___ Switzerland of Ohio - Skyvue
___ Switzerland of Ohio - Woodsfield
___ Switzerland of Ohio - Jack Cera
___ Warren - Warren
___ Wolf Creek - Waterford

Office Use Only	**Start Date:**	**SSID #:**
Dis. Condition:	**Services:**	**Preschool:**
Teacher:	**Poverty Level:**	**Typical**
IEP / Itinerant:	**By:**	**Entered EMIS √:**

ENROLLMENT PACKET

Child History:

Did mother have any unusual physical/emotional illness during pregnancy? ____Yes ____No
If Yes, Please explain:

Age of mother when child was born: | Child's Birth Weight:

Child was: (please check) ____Full Term ____Early ____Late If applicable how early/late?

Did the child have any sickness/problems? ____Yes ____No If Yes, Please explain:

Please indicate at what age the child began the following activities:
Walked alone _____ Was Toilet Trained _____
Spoke in Sentences _____ Dressed Self _____

How does this child's development compare to other children (siblings or playmates)?
(please check) ____About the same as others ____Slower than others ____Faster than others

Please list/describe allergies (to medications, foods, plants, animals) and reactions to these items:

Please list/describe recommended treatment to these reactions:

Please list any severe injuries, illnesses, surgeries you child has had:

Injury/Illness/Surgery	Was the child hospitalized?	Age at time of event?
1.		
2.		
3.		

Please describe any medications, food supplements, modified diet or fluoride supplements, the child takes daily and/or frequently:

Medication/Supplements	Reason taken?	How often?
1.		

Please check ☑ any health conditions the child has/had:

- Abnormal spinal curvature
- Allergies/hay fever
- Anemia
- Anaphylactic reaction
- Asthma or wheezing
- Attention Deficit Disorder
- Behavior problems
- Birth/Congenital malformation
- Cancer – Type_____
- Chicken pox – date_____
- Chronic diarrhea/constipation
- Chronic ear infections
- Concern about relationships
- Cystic Fibrosis
- Diabetes
- Eczema/Chronic skin condition
- Emotional problems
- Eye problems or poor vision
- Frequent headaches
- Frequent sore throats
- Heart disease – type _____
- Hemophilia
- Hepatitis
- Hyperactivity
- Kidney disease – type _____
- Measles
- Meningitis or Encephalitis
- Mumps
- Near-drowning/near suffocation
- Nervous twitches or tics
- Poisoning
- Rheumatic fever
- Seizure disorder/epilepsy
- Sickle cell disease
- Speech difficulties
- Stool soiling
- Toothaches/dental problems
- Urinary tract infections
- Wetting during day or night
- Other _____

PARENT INITIALS _____

ENROLLMENT PACKET

Emergency Contacts: Please list 3 people to be contacted in the event of an emergency IF the parent cannot be contacted.		
Contact #1:	Contact #2:	Contact #3:
Street Address	Street Address	Street Address
City State Zip	City State Zip	City State Zip
Relationship to Child:	Relationship to Child:	Relationship to Child:
Phone #	Phone #	Phone #
Cell #	Cell #	Cell #
Work #	Work #	Work #

Child's Name: First Middle Last		
Authorization to Release Child: My child may be released to his/her parent/guardian AND the following people only (without prior written authorization).		
Name	Relationship to Child	Phone #
My child may NOT be released to the following individuals: Please attach a copy of divorce decree and/or restraining order if applicable.		
Name	Relationship to Child	Please note any special circumstances of which the staff should be aware:

Please indicate if the family is involved with any of the following community services:	
Speech Therapy: __Yes __No If yes, where?	Head Start/Early Head Start: __Yes __No
Occupational Therapy: __Yes __No If yes, where?	Help Me Grow/Early Intervention: __Yes __No
Physical Therapy: __Yes __No If yes, where?	Job & Family Services: __Yes __No If yes, caseworker?
Hearing Services: __Yes __No If yes, where?	Child/Protective Services: __Yes __No If yes, caseworker?
Vision Services: __Yes __No If yes, where?	Preschool/Day Care: __Yes __No If yes, where?
Mental Health/Individual/Family Counseling Services: __Yes __No If yes, where?	
MUST HAVE A PHYSICIAN/DENTIST LISTED:	
Physician's Name:	Dentist's Name:
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone #	Phone #
Fax #	Fax #

PARENT INITIALS _____

ENROLLMENT PACKET

Things I would like my child's preschool teacher to know:

My child is: ____very active ____normally active ____not very active

My child prefers playing: ____alone ____with other children

My child has become violent or acted out in the following manner towards other children or adults. (please check all that apply) ____Hitting ____Kicking ____Biting ____Fighting ____Scratching
____My child has never become violent or acted out toward others.

If my child becomes upset, they calm themselves by:_____

I have concerns about how my child gets along with other children. ____Yes ____No
If yes, please explain:

My child's favorite color is: _____ My child's favorite book is: _____
My child's favorite food is: _____ My child's favorite toy is: _____
My child likes to: ____Listen to stories ____Play inside ____Play outside ____Draw/Color ____Play quite games
____Play pretend/make believe ____Other _____

I would like for my child to be able to:

Please add any comments or concerns that you have about your child's health, development, behavior, family or home life that you would like the school to be aware of.

Authorization for School District Transportation: Please initial on the appropriate line below.

____Yes, I grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate.

____Yes, I grant permission for my child to participate in walking field trips that are close to my child's school.

____No, I DO NOT grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate.

____No, I DO NOT grant permission for my child to participate in walking field trips that are close to my child's school.

Authorization for Annual Class Roster: Each year we prepare a roster for each group of children in our program. This roster will not be shared with any person other than the parents of children enrolled in our program.
I authorize the following information to be listed on the Class Roster (please check):
My Child's Name: ____Yes ____No Parent/Guardian Home Phone Number ____Yes ____No
Parent/Guardian Name: ____Yes ____No Parent/Guardian Cell Phone Number ____Yes ____No

PARENT INITIALS _____

ENROLLMENT PACKET

Authorization for Picture Publication: Please initial on the appropriate line below.

____Yes, I grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, or other social media etc.) Furthermore, I grant permission for my child to be videotaped and understand that it may be used for professional development and/or advertising purposes.

____No, I DO NOT grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, etc.) Furthermore, I DO NOT grant permission for my child to be videotaped and understand that it may be used for professional development and/or advertising purposes.

As the parent/guardian of _____. I authorize the information as listed above *(Authorization to Release Child, Authorization for School District Transportation, Authorization for Annual Class Roster,* and *Authorization for Picture Publication).*

→ _____
Parent/Guardian Printed Name

→ _____
Parent/Guardian Signature Date

Authorization for Participation and Release of Information:

My child has permission to participate in any health/developmental/academic screenings and assessments (which may include, but are not limited to physical, dental, vision, hearing, speech, mental health, lead, iron, height, weight, developmental, etc.) that are conducted through the Ohio Valley Educational Service Center, Bright Beginnings Preschool and other community agencies.

The Ohio Valley Educational Service Center has my permission to conduct assessments as required by the Ohio Department of Education (which may include, but are not limited to the Early Learning Assessment, Child Outcomes Summary Process, etc.) I understand that my child's teacher/specialist will provide feedback regarding the assessment to myself and other staff members working with my child. Additionally, I grant permission for the preschool administration to report the results of these assessments electronically, as required by law, to the Ohio Department of Education.

I understand that there may be some screenings/assessments that are not able to be conducted at my child's preschool setting and that I may need to obtain these screenings/assessments through my child's physician, dentist, local health department or other community agencies. I also understand that it may be necessary to obtain follow-up care for my child based on the results of the health/developmental assessments performed and that it will be my responsibility to do so.

The Ohio Valley Educational Service Center has my permission to share my child's information with all agencies that fall under the Department of Children and Youth as required by law, specifically the county office of Jobs and Family Services. This information may include any part of your child's enrollment application and/or proof of income.

As the parent/guardian of _____, by signing, I am verifying that I have read, understand and agree with the above information.

→ _____ _____ _____
Parent/Guardian Printed Name Parent/Guardian Signature Date

PARENT INITIALS _____

Child's Name:_____ Form updated: 12.20.2024

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

2025 FEDERAL POVERTY GUIDELINES

OHIO VALLEY EDUCATIONAL SERVICE CENTER

2333-B State Route 821, Complex 3, Bldg 16B, Marietta, OH 45750 / 740-373-6669

OFFICE USE ONLY

Size of Family Unit	2025 Federal Poverty Level (100%) Annually	110% Poverty Level	125% Poverty Level	185% Poverty Level	200% Poverty Level	Full Tuition
1	$15,060	$16,566	$18,825	$27,861	$30,120	
2	$20,440	$22,484	$25,550	$37,814	$40,880	
3	$25,820	$28,402	$32,275	$47,767	$51,640	
4	$31,200	$34,320	$39,000	$57,720	$62,400	
5	$36,580	$40,238	$45,725	$67,673	$73,160	
6	$41,960	$46,156	$52,450	$77,626	$83,920	
7	$47,340	$52,074	$59,175	$87,579	$94,680	
8	$52,720	$57,992	$65,900	$97,532	$105,440	

Parents: Due to state reporting requirements, we are required to gather income information for your family. This information in no way will be used to determine if your child qualifies for services and/or what services your child will receive. Simply find the number of family members that are in your household, and determine the dollar amount that is closest to your family's gross income. Please circle the dollar amount in that particular row that most closely reflects the gross income for your family.

If you have any questions, please contact the OVESC office at 740-373-6669.

MUST submit for Placement: Please Provide ONE of the following types of proof of income. Thank you.

* 3 most recent pay stubs **OR**
* A statement from Ohio Department of Job & Family Services caseworker stating your poverty level **OR**
* A copy of your most recent tax return showing gross income **OR**
* SNAP or Medical card approval letter

_____ **Parent/Guardian Signature**

every family MUST sign this form

Early Childhood Education Grant
Zero Income and McKinney-Vento Statement

Families with no income must provide a written explanation of how they are meeting basic living expenses, including food, housing/shelter, utilities and transportation.

The McKinney-Vento Act provides resources for children of families that are experiencing homelessness. Preschool students experiencing homelessness are eligible for immediate enrollment in programs with Title 1 funding. Homelessness is defined as:

Individuals who lack a fixed, regular, or adequate nighttime residence and includes:

1. *Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;*
2. *Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation;*
3. *Children who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and*
4. *Migratory children who qualify as homeless because they are living in circumstances described in 1-3 above.*

I, _____, verify that neither I nor any member of my family earns/receives any income.

I, _____, verify that my family meets the definition of homelessness.

Briefly describe how your family is meeting food, housing, utilities and transportation needs:

I certify that the information above is complete and accurate to the best of my knowledge. I understand that if I knowingly give false information or misrepresentation of my income, it may result in disqualification.

- Parent/Guardian Printed Name: _____
- Parent/Guardian Signature: _____ Date: _____

Witness Printed Name: Joy Edgell

Witness Signature: Mrs. Joy K. Edgell Date: _____

INCOME/and ASSISTANCE FORM

MUST be filled in for your child's application to be COMPLETE:

Please check if you receive:

- ◯ SNAP
- ◯ Medical Card
- ◯ Cash Assistance

If you marked yes - please submit a copy of your APPROVAL letter with this application

EVERYONE MUST provide ONE of the following with this application for the application to be processed.

- ◯ SNAP, medical card or cash assistance approval letter
- ◯ A copy of your most recent tax form, showing gross income
- ◯ 3 most recent pay stubs

You may be contacted later to provided additional income statements

The following CHILD CARE ASSISTANCE form must be completed by every family. You only need to complete the circled/HIGHLIGHTED sections and ensure your signature is at the end of the form

SNAP, CASH, MEDICAL, AND/OR CHILD CARE ASSISTANCE APPLICATION

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. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

Step 1: Check the box for each program the applicant wants to apply for

You can apply for any and all of the programs listed below. If you do not check any boxes, we will only review your eligibility for SNAP.

☐ SNAP ☐ Child Care Assistance ☐ Medical Assistance

☐ Cash Assistance - For families with a minor child(ren) or women who are pregnant

☐ Refugee Cash Assistance (RCA) - For refugees within 12 months of arrival ☐ ECE

Step 2: Tell us about the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

First Name	Middle Initial	Last Name

Do you need any of the following services?

☐ Large Print Notices ☐ Sign Language Interpreter

☐ Translator ☐ Other _____

What is your preferred language?

Spoken: _____

Written: _____

Have you, or anyone living with you, ever received SNAP, Cash, Medical, or Child Care Assistance?

☐ **No**

☐ **Yes -** If yes, who: _____

Location (City/County/State): _____

_____

_____

Step 3: Tell us how to reach the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

Home Address ☐ Check here if you do not have a permanent address - please provide a mailing address

City	State	Zip Code

Phone *(Cell)*	Phone *(Home)*	Email Address

Address where you get mail (if different)

City	County	State	Zip Code

Reminder: Did you tell us which program(s) the applicant is applying for? Make sure to check the appropriate box(es) in Step 1.

Step 4: Tell us if you are an Authorized Representative

An Authorized Representative is someone who helps the applicant with the application process and can act on the applicant's behalf. ***If you are filling out this form as an Authorized Representative, please give us the following information about yourself. You may be asked to give an authorization document.*** *You will not be listed as an Authorized Representative until the document is provided.*

First Name	Middle Initial	Last Name

Street Address

City	State	Zip Code

Phone *(Cell)*	Phone *(Home)*

Email Address

Do you need any of the following services?

- ☐ Large Print Notices
- ☐ Sign Language Interpreter
- ☐ Translator
- ☐ Other _____

What is your preferred language?

Spoken: _____

Written: _____

Step 5. For SNAP Applicants and SNAP Authorized Representatives ONLY

By signing below, you agree that you have **reviewed and agree to the terms in Step 14** and you certify, under penalty of perjury, the truth of the information contained in this application, including information provided below concerning citizenship and alien status of the members applying for benefits.

While you may submit your application with only the information provided above, your application may be processed more quickly if you continue to provide responses to the questions below.

Signature of Applicant OR Authorized Representative	**Date**

Print Name of Applicant OR Authorized Representative	**Date**

Step 6: Answer the following ONLY if applying for SNAP benefits

How many people live with you and buy, fix, and eat meals with you?_____

This number is considered your **"household"**, keep this in mind when answering the next two questions.

Note: *Your responses will help us decide if you can get SNAP more quickly. If someone else you live with is already receiving SNAP benefits, you may still be eligible for SNAP benefits.*

Is your household's total gross income before taxes for the current month less than $150? ☐ **Yes** ☐ **No**

Is your household's total net income for the current month zero after taxes and paying for such things as housing costs, child/dependent care costs, or child support payments?	☐ Yes ☐ No
Are your total resources in cash, checking, and savings accounts $100 or less?	☐ Yes ☐ No
Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes?	☐ Yes ☐ No
Are you a migrant or seasonal farm worker?	☐ Yes ☐ No

Step 7: Tell us the applicant's information

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, write your answers on an extra piece of paper and attach it to this form. **Please use the following to assist with completing the section below:**

- **Social Security Number (SSN):** If you, or anyone else in your household, is NOT a U.S. citizen, or a Qualified Non-Citizen, you do not have to give us an SSN. If there are other reasons that you, or someone in your household does not have an SSN, please write that below. (ex: pending SSA application)
- **U.S. Citizen:** You only have to tell us if someone is a U.S. citizen if they are for SNAP, Cash, Medical, or Child Care Assistance.
- **Race/Ethnicity:** Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic (Hispanic or Latino) information. Providing this information is voluntary and is used for informational purposes only. If you do not want to give us this information, it will have no effect on your case.

Name	Relationship to You (spouse, friend, etc.)	SSN (See instructions above)	Date of Birth	Sex	U.S. Citizen	Hispanic or Latino	Race
	Self			☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	
				☐M ☐F	☐Y ☐N	☐Y ☐N	

Are you married? ☐ **No** ☐ **Yes -** If yes, spouse's name: _____

Are you, or anyone you are applying for, pregnant?

☐ **No** ☐ **Yes -** If yes, who and when is the due date? _____

Do you, or anyone you are applying for need in-home care or nursing home services?

☐ **No** ☐ **Yes-** If yes, who?

Are you or anyone in your household caring for a disabled person in or outside of the home?

☐ **No** ☐ **Yes -** If yes, who? _____

Are you or anyone in your household in the military?

☐ **No** ☐ **Yes -** If yes, please select all that apply: ☐ **Active Duty** ☐ **National Guard/Reserves**

Have you ever been found guilty of Child Care fraud? ☐ **No** ☐ **Yes**

Step 8: Household members 60 years of age or older

Is anyone 60 years of age or older?

☐ **No -** If no, please skip to Step 9. ☐ **Yes -** If yes, answer the following questions in Step 8.

Is this person(s) receiving disability benefits?

☐ **No** ☐ **Yes -** If yes, from what source? _____

Is this person(s) unable to prepare meals due to a disability? ☐ **No** ☐ **Yes**

If you answered "Yes" to all three questions in Step 8, does this person(s) want to receive SNAP separately from the other people you live with? ☐ **No** ☐ **Yes**

Step 9: Tell us about the household's finances

Have you or the people in your household received, or expect to receive, income* this month?

☐ **No** ☐ **Yes -** If yes, please complete the table below.

***Income** refers to all the money that you and the people in your home receive. This includes earnings from employment or self-employment, child or spousal support, disability benefits, retirement benefits, Workers' Compensation, Unemployment Compensation, Social Security, SSI, Veterans' Benefits, Ohio Works First (OWF), gifts of money from individuals, etc.

Name	Type of Income or Name of Employer	How Often Received *(weekly, bi-weekly, etc.)*	Income Amount *(before taxes)*	Date Last Received

How much do you and the people in your household have in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

Give your best estimate of the total amount: $_____

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

Did anyone in your household leave a job or lose a job within the last 60 days?

☐ **No** ☐ **Yes -** If yes, who? _____

When? _____

For what reason? _____

Is anyone in your household on strike from a job?

☐ **No** ☐ **Yes -** If yes, who? _____

This Form Continues on the Next Page

Step 10: Tell us about the applicant's household expenses

Check all that apply. List the amount for each expense.

☐ **Child/Dependent Care Costs:**
Estimated Amount Paid per Month: $_____

☐ **Child or Spousal Support Payments Made to Someone Outside Your Household**
Estimated Amount Paid per Month: $_____

☐ **Medical Expenses for Anyone Who is Disabled or Age 60 or Older.** These include expenses such as medical bills, prescriptions, health insurance premiums, transportation to medical appointments, or other medical services.
Estimated Amount Paid per Month: $_____

☐ **Rent, Mortgage Payments, Lot Rent, Property Taxes, Homeowners' Insurance, etc.**
Estimated Amount Paid per Month: $_____

Do you pay for heat or air conditioning? ☐ **Yes** ☐ **No**

I pay for the following utilities *(check all that apply)*:

☐ Telephone ☐ Trash ☐ Sewage ☐ Water ☐ Electric ☐ Gas

Step 11: If applying for Child Care Assistance, please tell us why the applicant needs child care

If you or the people in your home are working, attending school, or participating in a training program, ***please complete the table below with all qualifying activities.*** *If employed, please list your current employer. This includes self-employment and odd jobs.* ***If you need more space, write your answers on an extra piece of paper and attach it to this form.***

Household Member 1 Name	Employer / School / Training Information Name
Activity Phone Number	Start Date / End Date
Address	

Houshold Member Work / School / Training Schedule

☐ Sun From _____ to _____ ☐ Thurs From _____ to _____

☐ Mon From _____ to _____ ☐ Fri From _____ to _____

☐ Tues From _____ to _____ ☐ Sat From _____ to _____

☐ Wed From _____ to _____ ☐ Varies week to week _____

Household Member 2 Name	Employer / School / Training Information Name
Activity Phone Number	Start Date / End Date
Address	

Household Member Work / School / Training Schedule

☐ Sun From _____ to _____
☐ Mon From _____ to _____
☐ Tues From _____ to _____
☐ Wed From _____ to _____
☐ Thurs From _____ to _____
☐ Fri From _____ to _____
☐ Sat From _____ to _____
☐ Varies week to week _____

Household Member 3 Name	Employer / School / Training Information Name

Activity Phone Number	Start Date / End Date

Address

Household Work / School / Training Schedule

☐ Sun From _____ to _____
☐ Mon From _____ to _____
☐ Tues From _____ to _____
☐ Wed From _____ to _____
☐ Thurs From _____ to _____
☐ Fri From _____ to _____
☐ Sat From _____ to _____
☐ Varies week to week _____

Step 12: Tell us about the child(ren) who need(s) child care

Child 1 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive Child Care Assistance.

☐ **Yes** ☐ **No -** My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No -** My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **No -** My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes -** What is their schedule? From _____ to _____ ☐ **No -** My child is **NOT** in Head Start

Days/Hours Child Care is Needed

☐ Sun From _____ to _____
☐ Mon From _____ to _____
☐ Tues From _____ to _____
☐ Wed From _____ to _____
☐ Thurs From _____ to _____
☐ F From _____ to _____
☐ Sat From _____ to _____

Provider Name	Provider Address	City	State	Zip Code

↑ office will complete this section ↑

Child 2

Child 2 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive Child Care Assistance.

☐ **Yes** ☐ **No -** My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No -** My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **Yes** ☐ **No -** My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes -** What is their schedule? From _____ to _____ ☐ **No -** My child is **NOT** in Head Start

Days/Hours Child Care is needed

☐ Sun From _____ to _____
☐ Mon From _____ to _____
☐ Tues From _____ to _____
☐ Wed From _____ to _____
☐ Thurs From _____ to _____
☐ Fri From _____ to _____
☐ Sat From _____ to _____

Provider Name	Provider Address	City	State	Zip Code

Child 3

Child 3 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive Child Care Assistance.

☐ **Yes** ☐ **No -** My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No -** My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **Yes** ☐ **No -** My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes -** What is their schedule? From _____ to _____ ☐ **No -** My child is **NOT** in Head Start

Days/Hours Child Care is needed

☐ Sun From _____ to _____
☐ Mon From _____ to _____
☐ Tues From _____ to _____
☐ Wed From _____ to _____
☐ Thurs From _____ to _____
☐ Fri From _____ to _____
☐ Sat From _____ to _____

Provider Name	Provider Address	City	State	Zip Code

Child 4

Child 4 - Name *(First, Middle, Last)*	Child's Mother's Maiden Name	City of Birth

Relationship to Applicant	Child's Preferred Spoken Language

Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive Child Care Assistance.

☐ **Yes** ☐ **No -** My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care?

☐ **Yes** ☐ **No -** My child does **NOT** require Protective Child Care

If YES, is there a case plan?

☐ **Yes** ☐ **No -** My child does **NOT** have a case plan

Is the child in Head Start?

☐ **Yes -** What is their schedule? From _____ to _____

☐ **No -** My child is **NOT** in Head Start

Days/Hours Child Care is needed

☐ Sun From _____ to _____

☐ Mon From _____ to _____

☐ Tues From _____ to _____

☐ Wed From _____ to _____

☐ Thurs From _____ to _____

☐ Fri From _____ to _____

☐ Sat From _____ to _____

Provider Name	Provider Address	City	State	Zip Code

Does your child(ren) have a chronic health condition, developmental disability, or special need?

☐ **No -** My child does **NOT** have a chronic health condition, developmental disability, or special need

☐ **Yes -** Please fill out the chart below:

Name *(First, Middle, Last)*	**Describe Child's Specific Needs**

This Form Continues on the Next Page

Step 13: Tell us about the school attendance of the child(ren) who need(s) care

Note: Complete this section if any child(ren) is attending or will be attending Kindergarten or higher grade school

Child's Name *(First, Middle, Last)*	Current Grade Level	School Name and Address	School Hours *(ex: 8am - 3pm)*	Kindergarten Schedule	School Year Start End Date
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	

Step 14: Please review the following information carefully and sign on the last page

BY SIGNING THIS APPLICATION:

▶ **For all programs (SNAP, Cash, Child Care, and/or Medical Assistance), I acknowledge and agree:**

- To the questions on this form and certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or immigration status of each household member applying for assistance.
- The county Job and Family Services (JFS) office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of assistance and/or in some instances, I may be asked to give consent to the county JFS office to make those contacts.
- I may be required to cooperate with the child support enforcement agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the CSEA, a referral will be submitted to the agency on my behalf. I also understand that if I am not required to cooperate with the CSEA, I may request child support services by completing the Application for Child Support Services (JFS Form 07076).
- The county JFS office can assist me with getting required verifications as long as I cooperate.
- The law provides a penalty of fine or imprisonment, or both, for anyone convicted of fraudulently receiving assistance for which he or she is not eligible.
- My signature below gives the county JFS office permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child/spousal/medical support income.
- The status of non-citizen household members may be subject to verification by the United States Citizenship and Immigration Services (USCIS) through the submission of information from the application to USCIS through the Systematic Alien Verification and Eligibility (SAVE) System. The submitted information received from USCIS may affect the household's eligibility and level of benefits.
- My signature below gives my consent and authorizes the county JFS office to access the 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 JFS office in writing.
- You have the right to request a county conference and a state hearing if you disagree with the action taken on your case. To request a county conference you should contact your county JFS office or review your notices received in the mail.

Step 14: Please review the following information and sign (Continued)

If I applied for SNAP benefits, I acknowledge and agree:

- By signing this application, that information will be requested from the Income and Eligibility Verification System (IEVS) and information may be verified through whatever contacts are necessary to determine my eligibility.
- Social Security Numbers (SSNs) will be used to check the identity of household members, prevent duplicate participation, and make changes to my case. If any household member does not provide their SSN, they will be designated as a non-applicant. This means they will NOT be considered as an applicant and will not be eligible for SNAP. Providing any requested information, including the SSN of each household member, is voluntary. However, failure to provide requested information to establish my eligibility for assistance will result in the denial or reduction of SNAP benefits to my household. Information collected on the application may be disclosed to law enforcement officials for the purpose of apprehending individuals fleeing to avoid the law.
- If a court of law finds me guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, I will not be eligible for benefits for two years for the first offense, and permanently for the second offense.
- If a court of law finds me guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
- SNAP benefits are issued on the Ohio Direction Card and I am prohibited from using my SNAP benefits to purchase or sell firearms or controlled substances. I understand that I can use SNAP benefits to only buy eligible items. I cannot use SNAP benefits to buy non-food items such as alcoholic drinks, tobacco, etc.
- Any member of my household who intentionally breaks the rules may not get SNAP for one year for the first offense, two years for the second offense, and permanently for the third offense.
- If a court of law finds me guilty of having trafficked benefits for a total amount of $500 or more, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
- I am prohibited from selling, trading or purchasing SNAP benefits and cannot use someone else's SNAP benefits for my household. I can be disqualified from the SNAP program for any of these violations.
- I cannot use benefits to buy food for someone who is not a member of my household.
- If I am found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, I will be ineligible to participate in the SNAP for a period of 10 years.
- The information provided with my application for SNAP benefits will be subject to verification by Federal, State and local officials to determine if the information is factual and if any information is incorrect, my SNAP benefits may be denied. I may be subject to criminal prosecution for knowingly providing incorrect information.
- If I receive SNAP benefits that I should not have gotten:
    - I may be ordered to repay the benefits
    - I may be charged with fraud
    - I may be fined (up to $250,000) or sent to prison (up to 20 years) or both
    - I may be prohibited from receiving benefits in the future.
- I will be held liable for any SNAP benefits that I receive that I should not have gotten if my authorized representative gives incorrect information.
- If I do not agree with an action taken on my case, I can file for a county conference or a state hearing. I can ask for a county conference or state hearing online, be email or mail, or by contacting my county JFS office. I can ask someone to attend the hearing in my place with my signed authorization.
- If my case is chosen at random to make sure that I am eligible for the assistance I receive and that I am receiving the correct amount, I must cooperate if my case is reviewed. If I refuse to cooperate with a review, my benefits may be terminated.
- Within 60 days of applying and at any time while receiving benefits, an employed or self-employed person is not to voluntarily and without good cause, quit the job or reduce work hours to less than 30 hours per week or to earning less than the federal minimum wage x 30 hours to remain eligible to participate in SNAP.

If I applied for Cash Assistance benefits, I acknowledge and agree:

- By signing this application and receiving OWF Cash Assistance, I may be required to cooperate with the local Child Support Enforcement Agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the local Child Support Enforcement Agency (CSEA), a referral will be submitted to the agency on my behalf and any rights to all support

Step 14: Please review the following information and sign (Continued)

owed to me and the minor children in the assistance group will be assigned to the State of Ohio.

- By signing this application and receiving OWF Cash Assistance, I am assigning to the State of Ohio any rights to child or spousal support that is owed to me and/or the minor children in the assistance group during the Ohio Works First eligibility period.
- Cash benefits are issued on the EPPICard™. The EPPICard™ can be used at MasterCard member banks, ATMs and most retailers that accept MasterCard. I cannot use my EPPICard at liquor stores, casinos, gaming establishments, or any retail establishments that provide adult entertainment in which performers disrobe or perform in an unclothed state for entertainment purposes.
- I must activate my EPPICard™ within 90 days from when benefits and my first card is issued and that if my EPPICard™ is not activated within 90 days, my benefits will be removed from my account.

▶ **If I applied for Child Care benefits,** I acknowledge and agree:

- My county JFS office or ODJFS may share approval, denial, and submission status of my child care application to the provider(s) listed on this application or to any provider named as a result of a change to my application. I understand that the sharing of this information to any provider not listed on this application shall require the signing of a separate release per Ohio Revised Code.
- I will be able to use Publicly Funded Child Care (PFCC) benefits only for children who are eligible and only up to the maximum hours authorized by the county JFS office. To remain eligible for PFCC benefits, the required copayment (if applicable) must be paid by me to the provider. Failure to pay the required copayment may result in termination of PFCC benefits.
- If I am approved for child care assistance, I will be responsible for accurately recording my child's attendance at the child care program by utilizing an automated attendance tracking system. This includes registering in the system and creating personal identification information that I will use to access the system and to serve as my electronic signature. I understand that my child care provider is not permitted to record my child's attendance on my behalf and may not have access to my personal identification information. I understand that the attendance tracking system may take my photo or a photo of my designee/sponsor as part of the login and logout process. I understand that I am responsible for approving any changes that my provider makes in the attendance tracking system regarding my child's attendance at the program.
- If my child attends a Step Up To Quality rated program, and if an assessment is completed on my child, the data will be collected and reported to ODJFS.
- I have received an explanation regarding the requirements for determining child care eligibility, the reasons why I may not be eligible, my right to a state hearing, and my responsibility for reporting changes to the county JFS office 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 automated child care attendance tracking system.
- I must report any changes which affect my eligibility to the county JFS office, including changes in family income, hours of employment/training/education, family size, and address. I understand that I must report changes within 10 days of the date they occur.
- My signature also gives consent to issue a system generated statewide student identifier (SSID) for each child listed on this application.
- Information About Child Care Providers:
    - Parents may select any program approved to offer publicly funded child care. These programs include centers, family child care homes, in-home aides and child day camps located throughout the state of Ohio.
    - If you would like assistance with selecting a provider, you may contact your local Child Care Resource and Referral Agency.
    - You may use our Child Care Directory to look for programs that fit your child care needs at https://childcaresearch.ohio.gov. The directory allows you to search by location, type of program, services offered and days and hours of operation. Information is provided about each program including Step Up To Quality rating, any additional accreditation or affiliation, licensing inspections and substantiated complaints.
    - Step Up To Quality helps families choose child care programs that go beyond the minimum standards of licensing. Rated programs demonstrate higher levels of quality in a variety of ways. If you would like more information about the Step Up To Quality program, visit the DCY child care website at https://jfs.ohio.gov/child-care/step-up-to-quality/for-families.
    - You may also visit our website to learn more about Medicaid health screenings and early intervention services for your child. For this information, go to https://jfs.ohio.gov/child-care/resources/02-special-needs-child-care.
- If you would like to make a complaint about a Provider regarding suspected violations of licensing rules, you may contact the Child Care Policy Help Desk at 1-877-302-2347, option 4.

If I applied for Medical Assistance benefits, I acknowledge and agree:

- Under penalty of perjury, I have disclosed all annuities and other similar financial devices in which I and/or my spouse have any interest.
- By signing this application and receiving Medicaid, I am assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to me and/or to the minor child(ren) in my assistance group. I understand that I must tell the Ohio Department of Medicaid about any health insurance I have or about any third party responsible for my medical expenses. I give the Department the right to pursue medical support from an ex-spouse or parent. If I think that cooperating to collect medical support will harm my child(ren) or myself, I understand that I can tell the Department and I may not have to cooperate.
- That the Ohio Department of Medicaid will check my answers using Social Security numbers and information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security (DHS), and others. If the information does not match, the Ohio Department of Medicaid may ask me to send more information.
- The Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
  - My application for medical assistance is denied; or
  - My eligibility for medical assistance ends; or
  - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization, I understand that my medical assistance may be denied or discontinued.
- If I am permanently institutionalized or age 55 or older when I receive Medicaid benefits, after my death the Estate Recovery Program may recover payments for the cost of my care paid by Medicaid from my estate. The cost of my care may include the capitation payment that Medicaid pays to my managed care plan, even if the capitation payment is greater than the cost of the services I actually received.
- I authorize any person who furnishes health care, medical supplies, or services to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. I understand that I authorize the previously mentioned departments to exchange any information I have provided to enable the departments to determine my eligibility for medical assistance benefits.
- The Medicaid Program requires enrollment for most recipients into a Managed Care Plan. You will receive information in the mail about this if you are determined eligible for Medicaid.
- The Healthchek program offers preventative healthcare services to all Medicaid eligible children under age 21 and pregnant women. A Medicaid eligible child may receive free Healthchek screenings for vision and hearing.

I authorize _____ to be my representative for _____ program.
(Name of Auth Rep) *(Ex. SNAP, OWF)*

i. For Medicaid: You may be asked to provide further documentation of the authorization in order to comply with OAC 5160-1-33.

- If you need more than one authorized representative, please contact your county JFS office.

Signature of Applicant OR Authorized Representative

Print Name of Applicant OR Authorized Representative

- END OF APPLICATION -

IS YOUR APPLICATION COMPLETE?

Is anything missing:

- ◯ Birth Certificate
- ◯ Proof of Residency (utility bill)
- ◯ All written parts of the application are filled in and signed
- ◯ Child Care assistance information filled in and signed
- ◯ Immunizations
- ◯ Custodial paperwork (if applicable)
- ◯ Appropriate proof of income provided
- ◯ I have initialed the bottom of each page

Please submit all preschool application documents to

Stephanie Middleton

stephanie.middleton@ovesc.org

PLEASE KEEP THESE FORMS TO COMPLETE:

The medical and dental forms that need completed by your CHILD'S PHYSICIAN are attached.

These forms need to be completed and returned within 30 days of your child beginning preschool.

Please detach these two forms and return to the address below WHEN COMPLETE:

Ohio Valley Educational Service Center
OVESC BRIGHT BEGINNINGS PRESCHOOL
Broughtons Complex 3 - Building 16B
2333-B St. Rt. 821
Marietta, Ohio 45750

Fax: 1-740-439-0012

Thank you!

Ohio Valley ESC
Bright Beginnings Preschool

Child Medical Statement

Required for ALL children enrolled in Preschool, Special Education, and Early Childhood Education Grant Programs

Child's Full Name: _____ Date of Birth: ____/____/____

School: _____ Age: _____ Height _____ Weight: _____

Physician's Name: _____

I authorize my physician to release the completed medical statement to Bright Beginnings Preschool. (Fax: 740-376-5809)

Parent/Guardian Signature: _____ Date: _____

To be completed by Child's Physician

Allergies: _____ History: _____

Normal	Abnormal	General Appearance	Normal	Abnormal	Speech
Normal	Abnormal	Posture, Gait	Normal	Abnormal	Teeth, Gums
Normal	Abnormal	Nose, Mouth, Pharynx	Normal	Abnormal	Head
Normal	Abnormal	Bones, Joints, Muscles	Normal	Abnormal	Heart
Normal	Abnormal	Skin	Normal	Abnormal	Lungs
Normal	Abnormal	Muscular Coordination	Normal	Abnormal	Extremities
Normal	Abnormal	Eyes	Normal	Abnormal	Abdomen
Normal	Abnormal	Symmetrical Light Reflex	Normal	Abnormal	Genitalia
Normal	Abnormal	External Aspects	Normal	Abnormal	Development
Normal	Abnormal	Ears	Normal	Abnormal	Social/Emotional

Abnormal Glands (Lymphatic/Thyroid) Normal Abnormal Neurological Normal

Assessments/Screenings:

Lead No Yes: Date- _____ Vision Screen No Yes: Date- _____

Hemoglobin No Yes: Date- _____ Hearing Screen No Yes: Date- _____

Medications: _____

Limitations for school or health conditions (including food supplements, modified diets, activity restrictions, and health services):

_____

Please attach a copy of the most recent Immunization record
(required by Section 3313.671 of Ohio Revised Code and for attendance in preschool)

Exempt from immunizations: Religious Convictions Health Concern Other

I have examined this child and found he/she is in suitable condition for participation in group care.

_____ _____

Signature of Physician/Physician's Assistant/Clinical Nurse Specialist/Certified Nurse Date of Exam

Printed Name: _____

Address: _____

Phone: (____)_____-_____ FAX: (____)_____-_____

Ohio Valley ESC
Bright Beginnings Preschool

Child Dental Exam

Parent/Guardian: To ensure good dental health, every child needs to have a dental exam. This checkup may be done by your own dentist. If you/your child does not have a primary dentist, please call 740-373-6669 for the names/phone numbers of local dentists taking new patients.

Child's Full Name: _____ Date of Birth: ____/____/____

School: _____ Age: _____

Dental Clinic/Dentist's Name: _____

I authorize my dental clinic/dentist to release this document to Bright Beginnings Preschool. (Fax: 740-376-5809)

Parent/Guardian Signature: _____ Date: _____

To be completed by Child's Dentist

This child received the following treatment in my office:

- ☐ Dental Exam
- ☐ X-Rays Taken
- ☐ X-Rays Read
- ☐ Cleaning
- ☐ Topical Fluoride Application
- ☐ Sealants
- ☐ Emergency Treatment: _____
- ☐ Fillings
- ☐ Extractions
- ☐ Steel Crowns
- ☐ Space Maintainers
- ☐ Other: _____

☐ **ALL TREATMENTS ARE COMPLETE.**

☐ **TREATMENTS ARE NOT COMPLETE. THE FOLLOWING IS STILL NEEDED:**

- ☐ Take X-Rays
- ☐ Read X-Rays
- ☐ Sealants
- ☐ Topical Fluoride Application
- ☐ Other: _____
- ☐ Fillings
- ☐ Extractions
- ☐ Steel Crowns
- ☐ Space Maintainers

I have examined this child and found he/she is in suitable condition for participation in preschool.

_____ _____

Signature of Dentist Date of exam

Printed Name: _____

Address: _____

Phone: (____)_____-_____ FAX: (____)_____-_____