**School Readiness Packet Requirements**

**IMPORTANT:** DO NOT USE WHITEOUT ON ANY OF THE FORMS IN THIS PACKET. IF CORRECTIONS ARE NEEDED, CROSS OUT THE ERROR, MAKE CORRECTIONS, AND INITIAL THE CORRECTION.

Please contact the Early Learning Coalition to schedule an intake appointment. **You must choose a child care provider for your child(ren) prior to your appointment.** If you need assistance with this choice, please contact our office at 941-757-2910 for a custom list of providers based on your and your child’s needs.

<table>
<thead>
<tr>
<th>IDENTIFICATION</th>
<th>REQUIRED VERIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity of Parent</td>
<td>Government issued ID, driver’s license, employment ID or student ID. If not available provide two of the following: social security card, voter registration card, birth record, military document, school record, or pay stub.</td>
</tr>
<tr>
<td>Manatee County Residency</td>
<td>Florida driver’s license or Florida identification card with current address, signed and dated lease agreement, utility bill received in the last 6 weeks, pay stub received in the last 6 weeks</td>
</tr>
<tr>
<td>Date of Birth for Children</td>
<td>Birth certificate, immunization record, life insurance policy that has been in force for at least two years, passport, a valid military dependent identification card.</td>
</tr>
<tr>
<td>U.S. Citizenship for Child</td>
<td>U.S. birth certificate, U.S. passport, lawfully admitted alien document, citizenship or naturalization certificate, religious documents recorded in the U.S. shortly after birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PURPOSE FOR CARE</th>
<th>REQUIRED VERIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed 20 hours per week minimum</td>
<td>Six (6) weeks of current, consecutive paystubs or an Employment Verification Form completed by the employer. If Self-Employed provide most current tax return including Schedule C or copy of verifiable, documentable business income and expenses for previous three months.</td>
</tr>
<tr>
<td>Student - Full Time</td>
<td>School Verification Form completed by the school registrar or training coordinator. Must have 12 credit hours or 20 hours of classroom attendance in a technical school.</td>
</tr>
<tr>
<td>Student Part Time and Employed</td>
<td>School Verification Form completed by the school registrar or training coordinator. Employment Verification Form completed by employer or six weeks of current consecutive paystubs. Must have minimum of 20 hours per week combined work and school.</td>
</tr>
<tr>
<td>Disability</td>
<td>Copy of current award letter showing receipt of SSA/SSI, or disability verification form completed by the physician</td>
</tr>
<tr>
<td>Relative Care Giver</td>
<td>Copy of relative care giver award letter or TANF child Only verification.</td>
</tr>
<tr>
<td>Income Worksheet</td>
<td>Required by State that parent complete and sign the bottom of page 2. This is in addition to the employment and/or school verification required above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER REQUESTED INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unearned Income</td>
<td>Current verification must be provided if applicable. Additional information requested includes, but is not limited to child support received, documented alimony, Social Security benefits, worker’s compensation benefits, Reemployment assistance or reemployment compensation benefits, Veteran’s benefits, retirement benefits, Temporary cash assistance, and cash gifts.</td>
</tr>
</tbody>
</table>
**Application for Child Care Funding**

Using blue or black ink, please complete sections A, B, and C, then sign and date. **Do not use white-out.**

<table>
<thead>
<tr>
<th>COALITION USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELIGIBILITY:</td>
</tr>
<tr>
<td>Funding Agency</td>
</tr>
<tr>
<td>Funding Contract</td>
</tr>
<tr>
<td>Eligibility</td>
</tr>
<tr>
<td>AUTHORIZATION DATES:</td>
</tr>
<tr>
<td>Eligibility Authorized From</td>
</tr>
<tr>
<td>Next Redetermination Date</td>
</tr>
<tr>
<td>Purpose for Care</td>
</tr>
</tbody>
</table>

### A. PARENT/GUARDIAN IDENTIFYING INFORMATION

<table>
<thead>
<tr>
<th>Applicant Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Race</th>
<th>Social Security Number (optional)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Primary Phone Number</th>
<th>Work Phone Number</th>
<th>Email Address</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
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<thead>
<tr>
<th>Mailing Address (if different)</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
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<table>
<thead>
<tr>
<th>Other Parent/Guardian Name (if in household)</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Race</th>
<th>Social Security Number (optional)</th>
</tr>
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<tbody>
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</table>

### B. CHILDREN REQUIRING CARE

<table>
<thead>
<tr>
<th>Name of Child Needing Care</th>
<th>Applicant’s Relationship</th>
<th>Gender</th>
<th>Race</th>
<th>U.S. Citizen</th>
<th>Social Security Number (optional)</th>
<th>Date of Birth</th>
<th>Second Parent (if not in household)</th>
<th>Daily Fee (Daily Fee)</th>
</tr>
</thead>
<tbody>
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</table>

|                          |                          |        |      |              |                                  |               |                                    |                      |

### C. OTHER HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Race</th>
<th>Relationship to Applicant</th>
<th>Relationship to Children Above</th>
</tr>
</thead>
<tbody>
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You have the right to apply for assistance and to have a determination of your eligibility without regard to race, sex, age, disability, religion, national origin, ethnic background, marital status or political belief. If you have a disability that substantially limits your access to the ELC, please inform us so that reasonable accommodations can be made that do not cause you undue burden or hardship.

PRIVACY ACT STATEMENT: Social Security numbers are requested on this form under s.119.071 (5)(a)2., F.S., for the use in the records and data system of the Florida Office of Early Learning and Early Learning Coalitions. Social Security numbers will be used for routine data requests, state and federal reporting requirements, identification, and to verify eligibility for the School Readiness Program, including, but not limited to family income. Submission of social security numbers on this form is voluntary and not a condition of enrollment in the School Readiness Program.

**I certify that the above information is true and complete to the best of my knowledge.**

---

Client Signature  
Date

ELC Eligibility Specialist  
Date

Rev. 7.18.16
You have been determined eligible for school readiness/county services and must comply with the following terms and conditions to become and/or remain eligible. By your initials and signature on this form, you understand fully and agree to the following terms and conditions.

___ I agree to notify the ELC’s Family Services Department in writing, within 10 days of any change that could affect my eligibility including but not limited to:

- **Employment**: changes of employer, pay, work hours/schedule, loss of employment
- **Family Status**: marriage, divorce, separation, parent of any child residing in the home, birth of child
- **Income Change**: begin receiving or stop receiving any income and other income changes
- **Residence/Contact Info**: address changes, phone numbers, etc.
- **Maternity Leave**

___ I agree to provide documents or information required by ELC within the designated time period realizing that my services may be suspended or terminated otherwise.

___ I have received information on the various types of child care choice available. I understand that some funding sources limit my child care choices. I have had all child care choices explained to me and have made my choice of my own free will. I understand the selected child care provider must allow me to visit my child(ren) while they are in care.

___ I understand I have the right to confidentiality of child information and the right to inspect, review and request a copy of my child(ren)’s school readiness record.

___ I agree to pay the assessed parent fee and any additional charges that I may incur. This parent fee is due whether or not the child(ren) are in care and on ELC approved holidays. These charges may include but not be limited to late fees, returned check fees, cost of care in excess of the Coalition maximum reimbursement rate, etc. I understand that it is my responsibility to request/receive a receipt for parent fees paid to the provider and notify the ELC if I am denied a receipt.

___ I understand that I cannot transfer my child until all parent fees are up to date and if I transfer my child prior to obtaining authorization from the ELC I will be responsible for the full cost of care until I obtain authorization.

___ I understand that my child(ren)’s attendance in child care is important and agree to report absences to the child care provider as they occur. I understand that this program will pay for up to 3 undocumented absences and up to 7 documented absences each month realizing I may be required to pay for days not paid by the Coalition. Unreported absences of five or more days could result in loss of child care slot and/or termination of my assistance, requiring me to re-apply to the Wait List.

___ I understand I or my designee must sign my child(ren) in and out each day they are in care using my or my designee’s full first and last name and time of drop off/pick up. I further understand that if the Coalition monitors my provider’s attendance records and determines that I have not complied with this requirement the payment for those days will be disallowed and the provider has the right to request full payment from me.

___ I give consent for review/release/exchange of all information provided to determine my eligibility including but not limited to contacting the current or previous employers for verification of employment information, etc. I agree that necessary information concerning my child may be released to other appropriate agencies.
I give consent for all State and Federal funder agencies or funder personnel to review my record for evaluation or monitoring purposes. In addition, I understand that agency records relating to the program may be public records under Chapter 119, Florida Statutes.

I understand that this program receives funding from Manatee County Government and that from time to time County representative may request access to any or all Agency records relating to this program and/or the delivery of its services for the purposes of evaluating or monitoring the program or delivery of service. I understand that any records provided to the County shall become public records, may be subject to any applicable state or federal exemptions, and be inspected by third persons.

I understand the Florida’s Office of Early Learning and the Early Learning Coalition has the right to initiate and/or receive data either through direct contact or an automated data exchange process to establish the validity of household information provided by the applicant/recipient to receive program benefits. This will include but not necessarily be limited to: social security benefits, birth dates, immunization status and/or all sources of potential and reported earned and unearned income sources. (Employment records, unemployment benefits, TANF, Child Support, etc.)

I understand the ELC and/or its Contractor and/or my chosen child care provider will provide routine and ongoing developmental and health screenings. I give consent to these screenings with the understanding that I will receive the results and my child’s current child care provider will be given a copy of the screening results. I give permission to the ELC and/or its contractor and/or my child care provider to exchange information regarding the above mentioned developmental and health screening results.

I understand that if I do not wish to have my children screened I must complete form OEL-SR 24 – Parent Option to Decline Child Screening and submit to ELC for my child(ren)’s file.

I understand that early learning services are based solely on client eligibility, availability of funds, and enrollment priorities. These services are not an entitlement. I understand that if I am deemed ineligible for services through termination, suspension, etc. I may have to go on a wait list and my eligibility for the wait list must be approved.

I understand that at any time I do not agree with a decision regarding my child care funding I have a right to appeal that decision. I must notify the ELC staff in writing of my request to appeal and that I wish a supervisory review of my case within ten days of any detrimental decision regarding my case.

I certify that my family’s total assets do not exceed $1,000,000.

The information given in my application is true and complete to the best of my knowledge. I understand that if I knowingly give false information, provide inaccurate documentation, sign inaccurate attendance documents or fail to report changes in my circumstances, I will be liable for financial restitution and may be referred to the Florida Department of Financial Services for action and my child care funding will be terminated. The ELC will investigate suspected fraud cases.
### SECTION I. EARNED INCOME

**INCOME WORKSHEET for Eligibility and Parent Copayments**

Complete the following information about each adult family member in the household who is employed or participating in education:

#### Check One:
- [ ] Single Parent Household
- [ ] Two-Parent Household

Parent(s) with whom the child resides (include parents by marriage or adoption)

<table>
<thead>
<tr>
<th>Name of Person Who Works</th>
<th>Name, Address and Telephone Number of Employer(s)</th>
<th>Source of Earned Income</th>
<th>Gross Earned Income (before taxes)</th>
<th>Weekly Work Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Frequency</td>
<td>Amount</td>
</tr>
<tr>
<td>Parent 1:</td>
<td></td>
<td></td>
<td>Hit Weekly:</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hit Bi-weekly*:</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hit Semi-monthly*:</td>
<td>$</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Hit Monthly:</td>
<td>$</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Hit Annual:</td>
<td>$</td>
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<td></td>
<td></td>
<td>Total Gross Annual Earned Income:</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Education:</td>
<td>Name, Address and Telephone Number of School:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Parent 2:</td>
<td>Name, Address and Telephone Number of School:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Additional Household Member 1:</td>
<td>Name, Address and Telephone Number of School:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Additional Household Member 2:</td>
<td>Name, Address and Telephone Number of School:</td>
</tr>
</tbody>
</table>

*Biweekly means paid every other week; Semi-monthly means paid twice per month*
**SECTION II. DEDUCTIONS**

If any family member makes any of the following type of payments, check the type of payment made. Enter the case or account number, the amount paid, the name of the family member making the payment, and the date of the last payment. These payment types are to be deducted or excluded from total family income.

<table>
<thead>
<tr>
<th>Authorized Deductions</th>
<th>Case/Account Number</th>
<th>Monthly Amount</th>
<th>Annual Amount</th>
<th>Name of Family Member Making Payment</th>
<th>Date of Last Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child support payments made pursuant to a court order</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony paid pursuant to a court order</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Annual Authorized Deductions</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION III. UNEARED INCOME**

If any family member receives any of the following type of unearned income (or benefits), check the type of benefits received. Enter the case or account number, the amount received, and the name of the family member receiving the payment.

<table>
<thead>
<tr>
<th>Unearned Income Type</th>
<th>Case/Account Number</th>
<th>Monthly Amount</th>
<th>Annual Amount</th>
<th>Name of Family Member Receiving Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Stamps benefits and Family Subsistence Supplemental Allowance (FSSA)**</td>
<td>Exempt</td>
<td>$</td>
<td>Exempt</td>
<td>$</td>
</tr>
<tr>
<td>Housing assistance, including Military Housing Assistance</td>
<td>Exempt</td>
<td>$</td>
<td>Exempt</td>
<td>$</td>
</tr>
<tr>
<td>TANF cash assistance</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends/Interest</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Disability income</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td>$</td>
<td>$</td>
<td></td>
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</tr>
<tr>
<td>Veteran’s benefits</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Retirement benefits-including Social Security, railroad retirement or other types of pensions not previously identified</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Child Support received (list)</td>
<td>$</td>
<td>$</td>
<td></td>
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</tr>
<tr>
<td>Allimony received</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Worker’s Compensation benefits</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Unemployment Compensation benefits</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Income/money received from non-family members residing in the household</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Other unearned income (list):</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Total Annual Unearned Income</td>
<td>$</td>
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</tbody>
</table>

**Do not include in the calculation of Total Annual Unearned Income. For federal reporting purposes only.**

<table>
<thead>
<tr>
<th>Total Annual Gross Income (Earned Income + Unearned Income – Deductions)</th>
<th>Household Size (Include parent(s), children, and related adults in the home)</th>
<th>Required Family Contribution/Parent Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
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<td>$</td>
</tr>
</tbody>
</table>

I hereby certify that the information given in this worksheet is true and complete to the best of my knowledge. I understand that if I knowingly give wrong information, I may be liable for prosecution under state law and that School Readiness services may be terminated. I also understand that if any changes occur to the information on this worksheet, I will notify the coalition of those changes within ten (10) days.

Signature of Parent/Guardian | Date | Signature of Eligibility Determiner | Date |
|----------------------------|------|------------------------------------|------|

11/07/02

SR #100
Employment/Income Verification Form

In order to determine eligibility for a child care scholarship, the ELC must receive copies of the **most current consecutive six weeks** pay stubs or this form, completed by the employer, as documentation of a new job or if paystubs are not issued.

**SECTION I – GENERAL INFORMATION:** (To be completed by employer)

1. Employee Name: ___________________________ SS#____________________________

   Employee Address: ____________________________________________________________

2. Type of work performed by employee: __________________________

   Employment began: __________________

3. Number of hours worked: Per week: _____________ Number of days per week: __________

   Work schedule: From: ____________________ To: ____________________

   Circle Days of Work: Sunday   Monday   Tuesday   Wednesday   Thursday   Friday   Saturday

4. Hourly wage received by employee: $_______________ Date employment ended: ______________

5. Employee paid: _____________

   - Weekly
   - Bi-weekly
   - Semi-monthly
   - Monthly
   - Other

6. Does employee receive tips?   Y   N

   If Yes, show tips in Section III

7. Is employment year-round?   Y   N

   If No, specify # of months: 12 11½ 11 10½

   10 9½ 9 ½

   Other: __________

**SECTION II – EMPLOYER INFORMATION:** (To be completed by employer)

1. Employer Name: ___________________________

   Title: __________________

2. Business Name: ___________________________

   Phone #: __________________

3. Business Address: ___________________________

**SECTION III – RECORD OF PAY RECEIVED:** (To be completed by employer)

1. In the space below, list the most current and consecutive **SIX** weeks of checks or cash received by the employee along with the gross amount paid, hours worked and the date the checks or cash were issued.

   │ DATES OF PAY PERIOD │ DATE OF PAYMENT │ GROSS EARNINGS │ # OF HOURS WORKED │ TIPS │ NET PAY │
   └─────────────────────┼───────────────────┼─────────────────┼───────────────────┼──────┼───────────┘

2. Please explain any unusual gaps or overtime and do you expect them to reoccur? __________________________________________________________

**SECTION IV – EMPLOYER VERIFICATION:**

I certify under the penalty of perjury (a first degree misdemeanor punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding $1,000 pursuant to s. 837.012, or 775.082, or 775.083, F.S.) the information provided on this form is true and complete to the best of my knowledge. I know if I give false information on purpose, I may be subject to prosecution for fraud.

__________________________________________

Employer Signature

Title

Employer Name (Print or Type)

Date
School/Training Verification Form

Parents/Guardians:
If your purpose for care is attending school, have the school/training records office complete Section II of this form and return it to:

Early Learning Coalition of Manatee County
Attn: Family Services Dept
600 Eighth Avenue West, Suite 100, Palmetto, FL 34221
Phone: (941) 757-2900    Fax: (941) 757-2916

SECTION I – TO BE COMPLETED BY PARENT/GUARDIAN (STUDENT)

In order to determine eligibility for child care scholarship, we must verify school attendance on the below listed client. Please complete and return this form to the Family Services Department of the Early Learning Coalition as soon as possible.

Parent/Guardian Name ____________________________________________  Social Security Number ________________________________

I give permission for my school to release the following information to Early Learning Coalition of Manatee County, Inc.

Parent/Guardian Signature _________________________________________  Date __________

SECTION II – TO BE COMPLETED BY RECORDS OFFICIAL

1. Student Name: ________________________________________________  ID#: ________________________________

2. Student Address: ______________________________________________

3. Days of Attendance:  MON  From _____ To_____  SAT  From _____ To_____

   TUE  From _____ To_____  SUN  From _____ To_____

   WED  From _____ To_____  THU  From _____ To_____

   FRI  From _____ To_____  Course Semester Begins: _____ / _____ /_____

   Number of Credit/Clock Hours Student is Currently Enrolled: ______________

4. Major or Occupational Goal: ______________________________________

5. Name of School: ________________________________________________

   Address of School: ________________________________________________

6. Name of Records Official: _________________________________________

   Title of Records Official: _________________________________________

   Signature of Records Official ____________________________  Date __________

   Official Seal ____________________________

Phone Number of Records Official ____________________________

Rev. 7.18.16
Dear Medical Provider:

In order for a parent/guardian to qualify for child care assistance due to a disability, the disability must prevent them from caring for the child (ren) on a full time basis. If applicable, please answer the following questions to assist us in determining the applicant’s eligibility.

Print Parent or Guardian Name: ___________________________  SSN: (optional) ______________________

Eligibility for child care assistance based on a parent/guardian disability:

Choose one:  [ ] Is permanently disabled  [ ] Is temporarily disabled until ___________

**BRIEF DESCRIPTION OF DISABILITY:**

__________________________________________________________________________________________________
__________________________________________________________________________________________________

Does the parent/guardian need assistance in providing full time care for the child(ren):  [ ] Yes  [ ] No

If yes, briefly explain how disability prevents parent/guardian from caring for the child(ren) on a full time basis:

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Is temporary disability due to maternity leave:  [ ] Yes  [ ] No

If yes, how long is anticipated leave?  ________________________________

____________________________________________  __________________________
Medical Provider’s Signature  Date

____________________________________________  __________________________
Medical Provider’s Name  Phone

Medical Provider’s Address
Child Support Verification Form

Custodial Parent Name: ________________________________

If you are a Parent/Guardian/Foster Parent and do not live with the father/mother of all of the child(ren), you are required to inform us of the status of child support for each absent parent(s) at each placement and redetermination.

You need to provide proof of the amount of child support for each child counted in the household. Failure to complete and return this form can result in the loss of your child care scholarship.

I certify under the penalty of perjury (a first degree misdemeanor punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding $1,000 pursuant to s. 837.012, or 775.082, or 775.083, F.S.) the information provided on this form is true and complete to the best of my knowledge. I know if I give false information on purpose, I may be subject to prosecution for fraud.

ABSENT PARENT INFORMATION:
Absent Parent Name: ________________________________ He/she is the parent of: ________________________________

Is Child Support Court Ordered { } Yes { } No And: ________________________________

If yes, what State: ________________________________ Case #: ________________________________ And: ________________________________

SECTION ONE - NONRECEIPT OF CHILD SUPPORT: (To be completed by the parent/guardian only if you do not receive child support)
If you are not receiving child support, please explain why: ____________________________________________________________

Date Last Rec’d: ________________________________

Custodial Parent’s Signature: ________________________________ SSN: ________________________________ Date: ________________

SECTION TWO – RECEIPT OF CHILD SUPPORT: (To be completed by the parent/guardian only if you receive child support but not through a court order and if unable to get absent parent(s) to complete Section Three.)
________________________________________________________

Custodial Parent’s Signature: ________________________________ Date: ________________

SECTION THREE – COMPLETED BY ABSENT PARENT(S):
Choose and check the selection that applies to you:
1. ___ I do not pay child support. I have not paid child support since: ________________________________
2. ___ I consistently pay child support in the amount of ________________________________ per: week/bi-week/month (circle one).
3. ___ I pay child support that varies from week to week. In the past six weeks, I have paid the following amounts:

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Signature of Absent Parent: ________________________________ Date: ________________________________

Address: ____________________________________________ Phone: ________________________________

IF YOU HAVE A COURT ORDER FOR CHILD SUPPORT, PLEASE ATTACH PROOF. OBTAIN PRINTOUT & CASE # FROM CSE OFFICE WWW.MANATEECLERK.COM OR WWW.MYFLORIDACOUNTY.COM
Child Support Verification Form

Custodial Parent Name: ________________________________

If you are a Parent/Guardian/Foster Parent and do not live with the father/mother of all of the child(ren), you are required to inform us of the status of child support for each absent parent(s) at each placement and redetermination.

You need to provide proof of the amount of child support for each child counted in the household. Failure to complete and return this form can result in the loss of your child care scholarship.

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ABSENT PARENT INFORMATION:

Absent Parent Name: ________________________________

He/she is the parent of: ________________________________

Is Child Support Court Ordered { } Yes { } No And:

If yes, what State__________________ Case #: ____________________ And:

SECTION ONE - NONRECEIPT OF CHILD SUPPORT: (To be completed by the parent/guardian only if you do not receive child support)

If you are not receiving child support, please explain why: ____________________________________________________________

___________________________________________ Date Last Rec’d:

Custodial Parent’s Signature: ________________________________ SSN: __________________ Date: ________________

SECTION TWO – RECEIPT OF CHILD SUPPORT: (To be completed by the parent/guardian only if you receive child support but not through a court order and if unable to get absent parent(s) to complete Section Three.)

________________________________________

Custodial Parent’s Signature ______________ Date ______________

SECTION THREE – COMPLETED BY ABSENT PARENT(S):

Choose and check the selection that applies to you:

1. ___ I do not pay child support. I have not paid child support since: ________________________________

2. ___ I consistently pay child support in the amount of ____________ per: week/bi-week/month (circle one).

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   Date: __________ Amount Paid: __________
   Date: __________ Amount Paid: __________
   Date: __________ Amount Paid: __________
   Date: __________ Amount Paid: __________
   Date: __________ Amount Paid: __________

Signature of Absent Parent: ____________________________________ Date: ________________

Address: __________________________ Phone: __________________

IF YOU HAVE A COURT ORDER FOR CHILD SUPPORT, PLEASE ATTACH PROOF. OBTAIN PRINTOUT & CASE # FROM CSE OFFICE WWW.MANATEECLERK.COM OR WWW.MYFLORIDACOUNTY.COM
Family Needs Questionnaire

1. I would like information on receiving help for the following: (Please check all that apply)
   - I am in need of utilities assistance (shut-off notice)
   - I am in need of assistance with rent (eviction notice)
   - I am in need of food for my family
   - I am in need of clothing (gender/sizes __________________)
   - Other __________________________

2. Would you like information on health insurance/Medicaid/Kid Care for your children?
   - Yes  □  No  □

3. Would you like information on obtaining a doctor for yourself or your children?
   - Yes  □  No  □

4. Would you like information on obtaining a dentist for yourself or your children?
   - Yes  □  No  □

5. Do you have access to reliable transportation when you need it?
   - Yes  □  No  □

6. Would you like information on assistance with domestic violence or drug/alcohol abuse?
   - Yes  □  No  □  Specify: ________________________________

7. Would you like information regarding job placement/training, GED, ESOL?
   - Yes  □  No  □  Specify: ________________________________

8. Would you like information regarding the HIPPY (Home Instruction Program for Parents of Preschool Youngsters) program?
   - Yes  □  No  □

9. Would you like information on the following topics (please check all that apply)
   - Stress Management  □  Child Development Stages  □
   - Divorce/Single Parenting  □  Health and Nutrition  □
   - Toilet Training Tips  □  Grandparents/Relatives Caring for children  □
   - Speech and Hearing  □  Discipline Techniques  □
   - Inclusion/Special Needs  □  Budgeting  □
   - Other, please list: __________________________________________

[ ] I do not wish to complete a Family Needs Questionnaire at this time

Name: ____________________________________________________________
Address: __________________________________________ City: ____________ Zip: ____________
Phone: ____________________ Alternate Phone: ____________________ Best Time to Call: ______________
Signature: ________________________________________________________ Date: ____________________

Date Resources Sent To Customer: __________ Follow-Up Dates: __________ __________ __________
Notes: ________________________________________________________________________________

Staff Name_____________________________________________ Date Entered in EFS____________________
Dear Parent/Guardian:

Our funding sources often ask for feedback on how our services are assisting families. We would like for you to please tell us briefly how the assistance from the Early Learning Coalition of Manatee County has impacted your family.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

By signing below, you authorize the ELC to share (with names redacted) your story.