

REDETERMINATION BY MAIL

Packet Requirements



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

You are responsible for recertifying your eligibility before the due date or your child care funding could stop. The following list provides you with the documentation needed in order for your care to continue.

IDENTIFICATION	REQUIRED VERIFICATION
Identity of Parent	Driver's License or state issued identification card. If not available you need to provide two forms of identification that contain name and date of birth.
Date of Birth for Children	Birth Certificate, Shot Record, Baptismal Record, Insurance Policy issued within past two years, Passport or any legal document showing the child's date of birth.
U.S. Citizenship for Child	Proof of US Citizenship for the child is required. U.S. Birth certificate, Adoption papers, Evidence of U.S. Citizenship of at least one parent, Baptism certificate from the U.S. or Native American tribal document is required.
PURPOSE FOR CARE	REQUIRED VERIFICATION
Employed 20 hours per week minimum	Six (6) weeks of current, consecutive paystubs or an Employment/Income Verification form completed by the employer if paystubs are not issued . Self employed need to provide most current tax return including Schedule C or copy of verifiable, documentable business income and expenses for previous six months.
Student - Full Time	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.
Student Part Time and Employed	School Verification Form completed by the School Registrar or Training Coordinator. Employment/Income Verification Form completed by employer or six weeks of current consecutive paystubs. Must have minimum of 20 hours per week combined work and school.
Disability/Unearned Income	Copy of your federal disability letter showing the amount of monthly income and/or the enclosed Disability Verification Form. Copy of Award letter for SSA, SSI for child.
Relative Care Giver	Copy of Relative Care Giver award letter or TANF Child Only verification.
Income Worksheet	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.
OTHER REQUESTED INFORMATION	
Social Security Card (copy)	Optional: Information is not shared with other databases and is only used to help determine right to information when Eligibility staff are contacted via phone for confidential client information.
Child Support Verification	Needed for every absent parent. Must be completed by the absent parent if child support received is not court ordered. Third party verification must be completed if child support is not received.
Terms & Conditions	Must be read and initialed for each paragraph – signature and date required at bottom of page two.
Family Needs Questionnaire	Used to determine if there are agencies that ELC can link the family with for additional services.

Your signature and return of this packet means you have fully read, understand, and agree to the terms and conditions of your child care funding. If you have additional questions, contact a Family Services Specialist at **(941) 757-2900**.





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.*

COALITION USE ONLY	
ELIGIBILITY Funding Agency: _____ Funding Contract: _____ Eligibility: _____	ELIGIBILITY AUTHORIZATION DATES Eligibility Authorized From: _____ Next Redetermination Date: _____

A. PARENT/GUARDIAN IDENTIFYING INFORMATION

Applicant Last Name			First Name			MI			Other Parent/Guardian Name											
Date of Birth			Race/Gender			SSN Number			Date of Birth			Race/Gender			SSN Number					
Home Phone Number						Work Phone Number						Email Address						Marital Status		
Street Address									City			County			State			Zip		
Family Size									Primary Language Spoken in the Home											

B. CHILDREN REQUIRING CARE

Name of Child Needing Care	Relationship to Applicant	Race	U.S. Citizen	Gender	Social Security No.	Date of Birth	COALITION USE	
			<input type="checkbox"/> Y <input type="checkbox"/> N				Daily Fee FT / PT	
			<input type="checkbox"/> Y <input type="checkbox"/> N					
			<input type="checkbox"/> Y <input type="checkbox"/> N					
			<input type="checkbox"/> Y <input type="checkbox"/> N					
			<input type="checkbox"/> Y <input type="checkbox"/> N					

C. OTHER HOUSEHOLD MEMBERS

Name	Race	Gender	Date of Birth	Relationship to Applicant	Relationship to Children Above

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.

Client Signature

Date

Eligibility Specialist Signature

Date



Terms and Conditions for Financial Assistance



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 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 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 agree that my family will use appropriate conduct at the child care facility and at the ELC realizing I may not be served otherwise.

_____ I agree that necessary information concerning my child may be released to other appropriate agencies.

_____ 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 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 certify that 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.

_____ 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.

The Agency for Workforce Innovation – Office of Early Learning
INCOME WORKSHEET for Eligibility and Parent Copayments

SECTION I. EARNED INCOME

Complete the following information about each adult family member in the household who is employed or participating in education. Provide proof of all income and/or participation in education/training declared on this form.

Check One: **Single Parent Household** **Two-Parent Household**

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

Name of Person Who Works	Name, Address and Telephone Number of Employer(s)	Occupation	Gross Earned Income (before taxes)		Weekly Work Schedule		
			Frequency	Amount	Day of Week	From	To
Parent 1 :			<input type="checkbox"/> Hourly	\$	Monday		
			<input type="checkbox"/> Weekly	\$	Tuesday		
			<input type="checkbox"/> Bi-weekly*	\$	Wednesday		
			<input type="checkbox"/> Semi-monthly*	\$	Thursday		
			<input type="checkbox"/> Monthly	\$	Friday		
			<input type="checkbox"/> Annual	\$	Saturday		
					Sunday		
			Total Gross Annual Earned Income:		\$	Total Hours Worked Per Week:	

<input type="checkbox"/> Education	Name, Address and Telephone Number of School:	<input type="checkbox"/> Semester <input type="checkbox"/> Quarter <input type="checkbox"/> Other	Total Classroom/ Lab Hours Per Week:	
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Parent 2 :			<input type="checkbox"/> Hourly	\$	Monday		
			<input type="checkbox"/> Weekly	\$	Tuesday		
			<input type="checkbox"/> Bi-weekly*	\$	Wednesday		
			<input type="checkbox"/> Semi-monthly*	\$	Thursday		
			<input type="checkbox"/> Monthly	\$	Friday		
			<input type="checkbox"/> Annual	\$	Saturday		
					Sunday		
			Total Gross Annual Earned Income:		\$	Total Hours Worked Per Week:	

<input type="checkbox"/> Education	Name, Address and Telephone Number of School:	<input type="checkbox"/> Semester <input type="checkbox"/> Quarter <input type="checkbox"/> Other	Total Classroom/ Lab Hours Per Week:	
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Additional adult family members in the home who are employed (includes children over 18 who are not enrolled as full-time students in secondary schools** or their equivalent and related adults who are supported by the family)

Additional Household Member 1:			<input type="checkbox"/> Hourly	\$	Monday		
			<input type="checkbox"/> Weekly	\$	Tuesday		
			<input type="checkbox"/> Bi-weekly*	\$	Wednesday		
			<input type="checkbox"/> Semi-monthly*	\$	Thursday		
			<input type="checkbox"/> Monthly	\$	Friday		
			<input type="checkbox"/> Annual	\$	Saturday		
					Sunday		
			Total Gross Annual Earned Income:		\$	Total Hours Worked Per Week:	

Additional Household Member 2:			<input type="checkbox"/> Hourly	\$	Monday		
			<input type="checkbox"/> Weekly	\$	Tuesday		
			<input type="checkbox"/> Bi-weekly*	\$	Wednesday		
			<input type="checkbox"/> Semi-monthly*	\$	Thursday		
			<input type="checkbox"/> Monthly	\$	Friday		
			<input type="checkbox"/> Annual	\$	Saturday		
					Sunday		
			Total Gross Annual Earned Income:		\$	Total Hours Worked Per Week:	

* Biweekly means paid every other week; Semi-monthly means paid twice per month

** A school that is intermediate in level between elementary school and college (includes middle/high, vocational/technical, and college-prep schools)

SECTION II. UNEARNED 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. Provide proof of all payments received with this form.

✓	Unearned Income Type	Case/Account Number	Monthly Amount Received	Annual Amount Received	Name of Family Member Receiving Payment
	Alimony received		\$	\$	
	Child Support received (if multiple payments, list each separately):		\$	\$	
	1.		\$	\$	
	2.		\$	\$	
	3.		\$	\$	
	Dividends/Interest		\$	\$	
	Food Stamps benefits		\$	\$	
	Housing assistance from HUD issued directly to a landlord (and utilities)		\$	\$	
	Housing assistance from HUD issued directly to member of the household (and utilities)		\$	\$	
	Income/money received from non-family members residing in the household		\$	\$	
	Military FSSA housing assistance		\$	\$	
	Relative Caregiver benefit		\$	\$	
	Retirement benefits, including Social Security, railroad retirement, or other types of pensions not previously identified		\$	\$	
	Social Security Disability income		\$	\$	
	Supplemental Security Income (SSI)		\$	\$	
	TANF cash assistance		\$	\$	
	Unemployment Compensation benefits		\$	\$	
	Veteran's benefits		\$	\$	
	Worker's Compensation benefits		\$	\$	
	Other income (list):		\$	\$	
	1.		\$	\$	
	2.		\$	\$	
\$					Total Annual Unearned Income

SECTION III. 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. The caseworker will deduct or exclude these payment types from total family income upon receipt of proof of payment.

✓	Authorized Deductions	Case/Account Number	Monthly Amount Paid	Annual Amount Paid	Name of Family Member Making Payment	Date of Last Payment
	Alimony paid pursuant to a court order		\$	\$		
	Child support payments paid pursuant to a court order		\$	\$		
\$					Total Annual Authorized Deductions	

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) calendar days.

Signature of Parent/Guardian	Date	Signature of Eligibility Determiner	Date
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OFFICIAL USE ONLY – Coalition staff to complete this section.

Total Annual Gross Income (Earned Income + Unearned Income – Deductions)	Household Size (Include parent(s), children, and related adults in the home who are supported by the family)	Required Family Contribution/Parent Copayment
\$		\$

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)

- Employee Name: _____ SS# _____
Employee Address: _____
- Type of work performed by employee: _____ Employment began: _____
- Number of hours worked: Per week: _____ Number of days per week: _____
Work schedule: From: _____ To: _____ A.M. P.M.
Circle Days of Work: Sunday Monday Tuesday Wednesday Thursday Friday Saturday
- Hourly wage received by employee: \$ _____ Date employment ended: _____
- Employee paid: \$ _____ Weekly Bi-weekly Semi-monthly Monthly Other
- Does employee receive tips? Y N If Yes, show tips in Section III
- Is employment year-round? Y N If No, specify # of months: 12 11½ 11 10½
 10 9½ 9 Other: _____

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

- Employer Name: _____ Title: _____
- Business Name: _____ Phone #: _____
- Business Address: _____

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

- 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

- Please explain any unusual gaps or overtime and do you expect them to reoccur? _____

SECTION IV – EMPLOYER VERIFICATION:

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. **Self-employment must be documented** by submitting employment log or business records/receipts for expenses.

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, Inc.
Attn: Family Services Dept
3526 Ninth Street West, Suite 200, Bradenton, FL 34205
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 ____ Course Semester Begins: ____/____/____
FRI From ____ To ____ Course Semester Ends: ____/____/____

Number of Credit Hours Student is Currently Enrolled: _____

Was the past course semester completed successfully? Yes No

If no, please explain: _____

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



Verification Form



Dear Medical Provider:

In order for a parent/guardian to qualify for a child care scholarship 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 scholarship 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



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

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.**

- If you **do not** receive child support and the absent parent(s) has no contact with the child(ren), complete **Section One**.
- If you do not have verification of child support but receive monies regularly, have a third party outside of your home but who can verify what you receive, complete **Section Two**.
- If you have contact with the absent parent(s), you must have the absent parent complete **Section Three**. Extra Forms are included for use if there is more than one absent parent.

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: _____

The information provided on this form is true and complete to the best of my knowledge. I fully understand that any omissions, falsifications or misrepresentations may disqualify my child(ren) from receiving child care scholarship and that I may be liable for prosecution under the full strength of the law plus repayment of ineligible child care services.

Custodial Parent's Signature: _____ SSN: _____ Date: _____

SECTION TWO - THIRD PARTY VERIFICATION (i.e. Relative, Friend, Eligibility Worker, etc):

For use only if unable to get absent parent(s) to complete Section Three. If there is no proof of receipt or non-receipt of child support, please explain what you know regarding child support.

The information provided on this form is true and complete to the best of my knowledge. I fully understand that any omissions, falsifications or misrepresentations I may be liable for prosecution under the full strength of the law.

Signature of Third Party _____ Date _____ Address _____

Telephone Number of Third Party _____

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:

Date: _____	Amount Paid: _____	Date: _____	Amount Paid: _____
Date: _____	Amount Paid: _____	Date: _____	Amount Paid: _____
Date: _____	Amount Paid: _____	Date: _____	Amount Paid: _____

Signature of Absent Parent: _____ Date: _____

Address: _____ Phone: _____



Child Support Verification Form



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

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.**

- If you **do not** receive child support and the absent parent(s) has no contact with the child(ren), complete **Section One**.
- If you do not have verification of child support but receive monies regularly, have a third party outside of your home but who can verify what you receive, complete **Section Two**.
- If you have contact with the absent parent(s), you must have the absent parent complete **Section Three**. Extra Forms are included for use if there is more than one absent parent.

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: _____

The information provided on this form is true and complete to the best of my knowledge. I fully understand that any omissions, falsifications or misrepresentations may disqualify my child(ren) from receiving child care scholarship and that I may be liable for prosecution under the full strength of the law plus repayment of ineligible child care services.

Custodial Parent's Signature: _____ SSN: _____ Date: _____

SECTION TWO - THIRD PARTY VERIFICATION (i.e. Relative, Friend, Eligibility Worker, etc):

For use only if unable to get absent parent(s) to complete Section Three. If there is no proof of receipt or non-receipt of child support, please explain what you know regarding child support.

The information provided on this form is true and complete to the best of my knowledge. I fully understand that any omissions, falsifications or misrepresentations I may be liable for prosecution under the full strength of the law.

Signature of Third Party _____ Date _____ Address _____

Telephone Number of Third Party _____

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:

Date: _____	Amount Paid: _____	Date: _____	Amount Paid: _____
Date: _____	Amount Paid: _____	Date: _____	Amount Paid: _____
Date: _____	Amount Paid: _____	Date: _____	Amount Paid: _____

Signature of Absent Parent: _____ Date: _____

Address: _____ Phone: _____

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 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 _____