Redford Service Learning Academy GSRP Application Information 2018-2019

Thank you for your interest in GSRP at Redford Service Learning Academy (RSLA). Great Start Readiness Program (GSRP) is a state funded program that provides a tuition free preschool for children that are 4 or will be 4 by September 1, 2018. After September 1st, if the program is not full, children who will be 4 by December 1, 2018 will be considered for the program. Because this program is a grant funded program, there are factors that a child must exhibit in order to be accepted into the program. The state of Michigan determines the following eligibility factors for this program:

- ✓ Extremely low family income
- ✓ Low family income
- ✓ Diagnosed disability or identified developmental delay
- ✓ Severe or challenging behavior
- ✓ Primary home language other than English
- ✓ Parent/guardian with low educational attainment
- ✓ Abuse/neglect of child or parent
- ✓ Environmental risk

First, income is screened to see if your child is eligible for Head Start, GSRP, or a private based preschool. Students who fall into a certain quintile, based on income, will be accepted first. Once that process is done, the factors are screened depending on if your child is in fact GSRP eligible for current enrollment. Please note, the children who have the most qualifying factors and falls into the income quantile will be put on top of the prioritization list. GSRP is a program that wants to serve children who have the most qualifying factors first based on income! Children who are accepted will experience four full days of school, Monday through Thursday.

Some important things to keep in mind when applying for this program:

- ✓ **Proof of income needs to be submitted to verify income, along with child's birth certificate, immunization record, health appraisal, and parent ID (Please submit all documents with the application)**
- ✓ **Busing is an option, sign in/off by an adult is required**
- ✓ Proof must be submitted for all qualifying factors
- ✓ Attendance must be a commitment
- ✓ Home Visits and Parent Teacher Conferences are mandatory (2x a year)
- ✓ Parent Involvement is a key component of this program
- ✓ Parents will need to complete an assessment on their child (Ages and Stages)
- ✓ No children will be accepted into the program until the bill is signed into law, at best, after July

Once again, thank you for your interest in the GSRP program!

Sincerely,

Dena Fisher
Early Childhood Curriculum and Instructional Officer

WAYNE RESA Leading... Learning for All | SERVICE LEADERSHIP COLLABORATION EXCELLENCE

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

GSRP CHILD APPLICATION FORM

For office use only

Program/Location: _____

Teacher: _____

Student UIC#: _____

Date of Enrollment: _____ ***Date Dropped:*** _____

Program Year:

20____ - 20____

PARENTS/GUARDIANS COMPLETE THIS SECTION

CHILD'S NAME: _____ **BIRTHDATE:** _____ **SEX: F** ☐ **M** ☐

CHILD'S ADDRESS: _____ **CITY:** _____ **ZIP:** _____

HOME TELEPHONE: _____ **ALTERNATE TELEPHONE:** _____

BIRTH CERTIFICATE#: _____ **BIRTHPLACE (city, state or nation):** _____

Special Needs: _____ Diagnosed: ☐ Yes ☐ No

Does the child have an IEP? _____ Date of IEP: _____ Inclusive Classroom specified? ☐ Yes ☐ No

Parent/Guardian Name: _____ Relationship to Child: _____

Age at 1st Pregnancy: _____ (Father) / _____ (Mother) Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Race: _____ (see chart below) Child Ethnicity: Hispanic ☐ Yes ☐ No

American Indian or Alaska Native; Asian; White; Black/African-American; Native Hawaiian or Pacific Islander

List *ALL* household members for which you are financially responsible

NAME	BIRTHDATE	NAME	BIRTHDATE

Type of MEDICAID Insurance: _____ **Case #:** _____ **Child's Recipient ID#:** _____

OTHER Medical Insurance: (Type): _____ **Policy Number:** _____

☐ **NO health insurance**

Revised 5/22/2017

PARENTS/GUARDIANS COMPLETE THIS SECTION

IF NOT PARENT, PROOF OF GUARDIANSHIP CASE#: _____

	FATHER	MOTHER	Foster Parent(s)/Stepparent(s) or Guardian(s)/Relationship
Name:			
Home Address:			
Home Phone:			
Cell Phone:			
Birthdate:			
Home Language:			
Highest Grade or Degree completed:			
Occupation:			
Employer:			
Business Phone:			
Work/School Schedule: ***(Days & Times)***			

The above information is true and correct to the best of my knowledge. I understand that if any of this information changes, or is found to be incorrect, I am obligated to immediately notify this program. I understand that the above information and all information contained in the child's folder will remain **CONFIDENTIAL.** I hereby make application for my child to be enrolled in a Wayne County Great Start Readiness Program based on all the information on the Child's Application Form.

_____ _____

Parent's Name (print) **Parent's Signature** **Date**

STAFF COMPLETE THIS SECTION

At the time of registration, was proof provided of:

Birth Certificate (date received:_____)

Letters of Guardianship (date received:_____)

Income (date received:_____)

Immunization (date received:_____)

Health Appraisal (date received:_____)

Parent has been informed of Head Start Eligibility? ☐ Yes ☐ Not Applicable

Head Start Referral Release Form completed? ☐ Yes (please attach) ☐ Not Applicable

Date child entered the United States (if birth documents are from a foreign country): _____

RISK FACTORS: *STAFF COMPLETE THIS SECTION*

	CHECK ALL THAT APPLY:	***TYPE OF DOCUMENTATION*** *(i.e., parent report, pay stub, IEP, etc.)*
☐	**1. Low family income: Quintile # ___**	
☐	**2. Diagnosed disability**	
☐	**3. Severe or challenging behavior**	
☐	**4. Primary home language other than English**	
☐	**5. Parent/guardian with low educational attainment**	
☐	**6. Abuse/neglect of child or parent**	
☐	**7. Environmental risk**	

_____ _____

Staff Signature **Date** **Signature of ECS Reviewing Form** **Date**

Great Start Readiness Program
Determining Eligibility Factors (1-7) – Intake Questions

The following questions are designed to gather information from families while being aware of how sensitive these areas may be. Use these Intake Questions during the interviewing process and keep a completed form in the child's file as evidence of each family's eligibility and need for supports to the child and family.

Does your child have an individual education plan (IEP)? _____ Yes ____ No

Does your child have a chronic illness (example: asthma)? ____ Yes ___ No
- If yes, please explain: _____

Do you, a doctor, or other professional have any concerns regarding your child's development?
____ Yes ___ No
- If yes, please explain: _____

Has your child's behavior prevented participation in another group setting? ____ Yes ___ No

Is your child in counseling or therapy? ____ Yes ___ No

Has your child been expelled from preschool or child care center or other setting? ___ Yes __ No

What is your child's primary language? _____

Are there any languages other than English spoken in the home? ____ Yes ___ No
- If yes, what language? _____

What is the highest level of education for the parents of the child?
- Parent 1 (check all that apply):
  - Elementary school ____
  - Middle school ____
  - High school ____
  - Some College ____
  - Undergraduate degree _____
  - Beyond college _____
- Parent 2 (check all that apply):
  - Elementary school ____
  - Middle school ____
  - High school ____
  - Some College ____
  - Undergraduate degree _____
  - Beyond college _____

Are there any literacy resources, either for the child or parent, the family would be interested in?
_____

Great Start Readiness Program
Determining Eligibility Factors (1-7) – Intake Questions

Who reads to the child in the home?
_____

Have you or your child ever felt unsafe in your home? ____ Yes ___ No
- If yes, please explain: _____

Has anyone in your home been a victim of physical, sexual, or emotional abuse or neglect?
____ Yes ___ No

Is there a history of substance abuse in the home (alcohol, drugs, prescription drugs)?
____ Yes ___ No

Does anyone in the home have a violent or destructive temper? ____ Yes ___ No

Has any of the following occurred for the child?
- Divorce _____
- Parental:
  - Death _____
  - Military leave _____
  - Incarceration _____
  - Chronic illness _____
  - Living elsewhere due to school or work _____
- Grandparents raising child _____
- Foster child _____
- Frequent changes in custody _____
- Single parent _____
- Teen parent at the time the first child was born _____
- Sibling with:
  - Chronic illness _____
  - Challenging behavior _____
  - Disability _____
  - Death _____

How many times have you moved in the past 2 years? _____

Did your family unexpectedly relocate in the last 6 months? ____ Yes ___ No

Are you residing with anyone other than your immediate family members? ____ Yes ___ No

Do you consider yourself homeless? ____ Yes ___ No

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications: ⇨

_____ / /
Parent/Guardian Signature Date

Was the health history reviewed by a health professional?
☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ _____ ___/___/___

Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

_____ _____ MI _____ (_____)_____

Number & Street City ZIP Code Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

****

Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only: Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)					Child's Date of Birth
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Home Phone ( )	Parent/Legal Guardian's Name (Optional)		Home Phone ( )
Home Address (if not child's address)		Cell Phone ( )	Home Address (if not child's address)		Cell Phone ( )
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address		
Employer Name		Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)					
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)					

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

See Reverse Side

Emergency Contact & Release of Child: List all individuals,including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

Parent/Legal Guardian Initials:

_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian _____ Date Signed _____

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Community and Health Systems website at **www.michigan.gov/michildcare**.

I have read the above statement issued by _____.
Name of Child Care Center

Child(ren)'s Name(s) _____

_____

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

Redford Service Learning Academy
25940 Grand River Ave.
Detroit, MI 48240
Phone: 313.539.4115

Household Information Survey

SCHOOL USE ONLY
Approved for:
1 ☐ 2 ☐

Redford Service Learning Academy is participating in the Community Eligibility Provision (CEP) provision under the National School Lunch Program. Under CEP, all children in the school will receive a breakfast/lunch at no charge. However, to determine eligibility for various additional state and federal program benefits that your child(ren) may qualify for, please complete, sign, and return this application to **Redford Service Learning Academy.**

If any member of your household receives Food Assistance Program (FAP), Family Independence Program(FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Name: _____ Case Number: _____

INSTRUCTIONS: Complete survey and return to your child's school or mail to the address listed above.

These sections must be completed by the head of household or designee.

1. SIZE OF FAMILY - Indicate the total number of individuals living in your household, including all adults and children

2. STUDENT INFORMATION – Complete for each student Pre-K through 12th Grade

Last Name	First Name	Birth Date MM-DD-YYYY	School	Identify H if Homeless M if Migrant R if Runaway F if Foster
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

If you need additional lines, attach a second sheet to this survey or attach a copy of this survey clearly marked as a Page 2.

3. TOTAL MONTHLY HOUSEHOLD INCOME – Report income for all members of household excluding Foster Children. **If you have reported a case number above, you do not need to fill in this section. Simply sign and date form.**

Type of Income	Income	Circle if No Income
1. Gross Monthly Earnings: Wages, Salary, Commissions	$	None
2. Monthly Welfare Payments, Child Support, Alimony	$	None
3. Monthly Payments from Pensions, Retirement, Social Security	$	None
4. Monthly Dividends or Interest on Savings	$	None
5. Monthly Worker's Compensation, Unemployment, Strike Benefits	$	None
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	$	None
Total Monthly Household Income (Add lines 1-6)	$	

4. SIGNATURE - If Income Section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security Number or check the "I do not have a Social Security Number" box below.

I certify (promise) that all information on this application is true and that all income is reported. I understand that the sponsor will be eligible for certain federal and/or state funds based on the information I give. I understand that sponsor officials may verify (check) the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted.

Sign Here: X_____ **Print Name:** _____ **Date:** ____/____/2014

Last Four (4) Digits of Adult Social Security Number: XXX-XX-_____ ☐ I do not have a Social Security Number

Address **City** **Zip Code**

Home Phone	Work/Cell Phone	Email Address
		By providing your email address, you may be contacted via email by the district.

REDFORD SERVICE LEARNING ACADEMY

Walking Field Trips Consent

I hereby grant permission for my child to go on walking field trips with his/her class. These field trips may include walks to the park and into the community for Service Learning Projects.

Parent/Guardia Signature:_____ Date:_____

Approval for Photograph/Video

I, the undersigned, give the Detroit Service Learning Academy (DSLA) District and/or parties designated by DSLA District, the consent to have my child/ren photographed and/or video for educational and promotional purposes and also understand that I will not be financially compensated.

□ Yes, I consent to the above_____ Date:_____

□ No I do not give my consent_____ Date:_____

Student Transportation

Place an "X" in the appropriate box or boxes

□ Walker □ Bus public transportation □ Transported by parent/guardian □ Carpool

Parent/Guardia Signature: _____ Date: _____

Emergency/Early Dismissal

Place an "X" in the appropriate box or boxes

If school is dismissed early or for emergency meetings my child will:

□ Walker □ Bus public transportation □ Transported by parent/guardian □ Carpool

Parent/Guardia Signature:_____ Date:_____

Student Acceptable Use & Liability

As a student of the DSLA District, I agree to comply with the following computer guidelines:

- I will comply with the District computer lab rules by handling the computer equipment responsibly.
- I understand that the school computer software cannot be copied to any other computer this will violate the Copyright laws.
- I will not share my password or disclose any of my personal information to anyone outside of the DSLA District.
- The internet is used for educational and research purposes only.
- I will not access any inappropriate websites; access my on email, FB, twitter or instagram page while utilizing school computer equipment.

Student Name: _____ Grade: _____ Date: _____
(Signature)

Parent/Guardian Name: _____ Date: _____
(Signature)

Parent/Guardian Volunteer

□ Yes, I am interested in volunteering □ No, I am not interested at this time

Parent/Guardian Name:_____ Date:_____
(Signature)