GSRP Preschool Application 2024-2025

These materials were developed under a grant awarded by MiLeap

Benton Harbor-St. Joseph YMCA
3665 Hollywood Rd. St. Joseph, MI 49085

Child's Name: _____

Please check classroom preference:

- ❑ Monday-Thursday full day 8:45 AM-3:15 PM
- ❑ Monday-Thursday 1/2 Day 8:45 AM-12:30 PM
  Seats are limited and distributed as a first come, first serve.

Turn in the following items with your application packet:

- ❑ **Proof of Age:** Such as a Birth Certificate, passport, immigration record or baptismal certificate. Your child must be 4 by September 1. (Consideration for children who turn 4 from September 2-December 1)
- ❑ **Proof of Income:** Such as work earnings (W-2, tax return, or check stubs), child support, unemployment, SSI, cash assistance and any other proof of income
- ❑ **Proof of Residency:** Such as driver's license, rent receipt, utility bill, letter from shelter or host if between homes. You must live in Berrien County **or** Cross-County families will need to complete a Cross County Prior Approval form
- ❑ **If your child has an IEP** (Individual Education Plan) please include a copy
- ❑ **Completed copy of the Health and Immunization form** (included in this packet): **To be completed prior to your child starting GSRP.** This document will be completed from your child's doctor's office.
- ❑ **Transportation form:** Residence must be within the Niles Community School District to be eligible for transportation.

2024-2025	Head Start	Head Start	GSRP	GSRP	GSRP	GSRP	Tuition enroll on/after Sept. 1
Household Size	0-50%	51-100%	101-150%	151-200%	201-250%	251-300%	301-400%
1	0-7,530	7,531-15,060	15,061-22,590	22,591-30,120	30,121-37,650	37,651-45,180	45,181-60,240
2	0-10,220	10,221-20,440	20,441-30,660	30,661-40,880	40,881-51,100	51,101-61,320	61,321-81,760
3	0-12,910	12,911-25,820	25,821-38,730	38,731-51,640	51,641-64,550	64,551-77,460	77,461-103,280
4	0-15,600	15,601-31,200	31,201-46,800	46,801-62,400	62,401-78,000	78,001-93,600	93,601-124,800
5	0-18,290	18,291-36,580	36,581-54,870	54,871-73,160	73,161-91,450	91,451-109,740	109,741-146,320
6	0-20,980	20,981-41,960	41,961-62,940	62,941-83,920	83,921-104,900	104,901-125,880	125,881-167,840
7	0-23,670	23,671-47,340	47,341-71,010	71,011-94,680	94,681-118,350	118,351-142,020	142,021-189,360
8	0-26,360	26,361-52,720	52,721-79,080	79,081-105,440	105,441-131,800	131,801-158,160	158,161-210,880
For each additional family member add	2,690	5,380	8,070	10,760	13,450	16,140	21,520

Please note - Acceptance into a GSRP classroom does not guarantee that you will be accepted into that school's Kindergarten or Young 5's program, you will have to follow the process or school of choice process per school. All referrals for speech or special education services are required to be held with your local resident school districts.

BERRIEN COUNTY GSRP APPLICATION 2024-2025

By completing an application this doesn't automatically enroll you into GRSP. All applications/enrollments are pending per review of qualifications and the state GSRP budget. All final notifications will come from teachers/sites prior to the fall start.

PROGRAM PREFERENCE

☐ BH Charter ☐ BH Discovery Enrichment Center ☐ BH/Lylabugs & Buttons ☐ BH/The Blessed Noahs Ark
☐ Berrien Springs ☐ Berrien Springs/Trinity Lutheran ☐ Brandywine ☐ Bridgman/Immanuel Lutheran
☐ Buchanan Public School ☐ Coloma ☐ Eau Claire ☐ Niles/YMCA ☐ Niles/The Children's Center
☐ Saint Joseph/The Children's Center ☐ Saint Joseph/BH YMCA ☐ Watervliet

CHILD INFORMATION

Child's Legal Name: _____ _____ _____ Date of Birth: ___/___/_____
First Name Middle Name Last Name mm dd yyyy

Gender: ×Male ×Female

Ethnicity: Hispanic or Latino ×Yes ×No

Race: American ☐ African American or Black ☐ Indian or Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian or Pacific Islander ☐ Caucasian or White ☐ Two or more races_____

Address_____ City _____ Zip_____ County_____

Phone Number: _____ School District of Residence:_____

FAMILY INFORMATION

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Joint Custody (If joint, Physical or Legal, Explain) _____
☐ Legal Guardian ☐ Grandparents ☐ Foster Care ☐ Other: Explain _____

Parent/guardian Name 1:_____
Parent/guardian date of birth:_____
Address: (if different from above):_____
Current Employer:_____
Employers Address:_____
Primary Phone#:_____
Alternative Phone#:_____
Email: _____

Parent/guardian Name 2:_____
Parent/guardian date of birth:_____
Address: (if different from above):_____
Current Employer:_____
Employers Address:_____
Primary Phone#:_____
Alternative Phone#:_____
Email: _____

EMERGENCY CONTACTS other than parent/guardian

1. _____ _____ _____ _____ _____ _____
Name Street Address City State Phone Number Relationship to child
2. _____ _____ _____ _____ _____ _____
Name Street Address City State Phone Number Relationship to child

RISK FACTORS (Please mark all that apply)

01: Income: Annual Gross Income: $_____ # in your household_____

02: Diagnosed disability or identified developmental delay
- ☐ My Child has been referred or diagnosed with a disability/delay by a provider
- ☐ My Child has an IEP (IEP will need to be provided with application)

03: Severe or challenging behavior
- ☐ My child has been excluded/expelled from other preschool/child care programs
- ☐ My child has social services or medical referrals for behavior
- ☐ Other:

04: Primary and/or home language other than English
- ☐ Primary and/or home language is other than English _____

05: Parent/Guardian with low educational attainment
- ☐ One or both parents have no High School diploma or GED Certificate

06: Abuse/Neglect of the child or parent
- ☐ There has been abuse/neglect for the child or parent

07: Environmental risk
- ☐ There has been parental loss due to death, divorce, incarceration, military service or absence
- ☐ There has been sibling issues that have impacted my child
- ☐ I was under 20 when my first child was born
- ☐ Family is homeless (please mark all that apply below)
  - ☐ Doubled up: Sharing housing with others due to loss of housing, economic hardship, etc.
  - ☐ Lack of adequate accommodations: Living in a motel, hotel, car, park, campground (public or private place not designed for regular sleeping) or accommodations are inadequate (water, heat, space, etc)
  - ☐ Transitional Housing: Living in emergency transitional shelters/housing
  - ☐ Foster Care: awaiting placement (for 6 months from the date of placement)
  - ☐ Migrant: Migratory children living in any circumstances listed above
    - ☐ By marking any of the above homeless situations I understand I qualify for McKinney Vento Services and will be referred onto the District Homeless Liaison

08: None
- ☐ My child has none of the risk factors listed above

Parent/Guardian Signature_____ **Date**_____

FOR OFFICE USE ONLY FOR POWERSCHOOL STAFF: Teachers/Staff must complete this section
Teacher:_____Start Date: _____End Date:_____Child's Name:_____

% FPL: Quintile:
- ❑ 01 0-50%
- ❑ 02 51-100%
- ❑ 03 101-150%
- ❑ 04 151-200%
- ❑ 05 201-250%
- ❑ 06 251-300%(These families must pay for GSRP Tuition and considered after September 1st)
- ❑ 07 301-and above% (These families **do not qualify for GSRP**)

Eligibility Factors:
- ❑ 02 Diagnosed disability or identified developmental delay
- ❑ 03 Severe or challenging behavior
- ❑ 04 Primary and/or home language other than English
- ❑ 05 Parent/Guardian with low educational attainment
- ❑ 06 Abuse/Neglect of the child or parent
- ❑ 07 Environmental risk
- ❑ 08 None

Qualifying factors
- ❑ A Homeless (these families are Quintile 01: 0-50%)
- ❑ B Foster Care (these families are Quintile 01: 0-50%)
- ❑ C Qualifying IEP (these families are Quintile 01: 0-50%)
- ❑ D None

Application Prioritization Rank#____
Quintile:____ #of Risk Factors:____

____Family qualifies for HS: approved to be served in GSRP

2024-2025 Income/Age/Resident/IEP Verification Form

Berrien County GSRP Program

Child's Name: _____ Parent(s) Name:_____

Income Source Verification	**Amount Received**			
Documentation provided	**Annually**	**Monthly**	**Weekly**	**Biweekly**
Income tax Form 1040				
W-2				
TANF documentation				
Pay Stub or Pay Envelopes				
Unemployment				
Written statement from employer(s)				
Foster Care Reimbursement				
SSI documentation				
Child Support				
Alimony				
Pension(s)				
Other				
Documentation of no income				

Total of Income Documented Above: $_____ Number in Household: _____

I verify that I have provided true and accurate documentation as indicated above.

_____ _____

Parent/Guardian Signature Date of Verification

FOR OFFICE USE ONLY

I verify that I have reviewed the following documentation with the families:

- ❏ **Proof of Age:** Such as a Birth Certificate, passport, immigration record or baptismal certificate
- ❏ **Proof of Income:** Such as work earnings (W-2, tax return, or check stubs), child support, unemployment, SSI, cash assistance and any other proof of income.
- ❏ **Proof of Residency:** Such as driver's license, rent receipt, utility bill, letter from shelter or host if between homes.
- ❏ **If a child has an IEP** (Individual Education Plan) copy has been reviewed

_____ _____

GSRP Staff Signature Date of Verification

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PERMISSION FORM FOR OUTSIDE SCREENING/SERVICES

Child's Name_____ School/Site_____

I _____(parent/guardian name) give permission for _____ (child's name) to receive the following services outside of the GSRP classroom.

The following screening/services may be provided:

- Speech screening and/or services
- OT screening and/or services
- PT screening and/or services
- Vision screening and/or services
- Hearing screening and/or services
- Kindergarten screening
- Other_____

I am aware that all school staff and volunteers receive a background check and understand it is not the same comprehensive check as the GSRP teachers. I understand that my child will be screened or provided services outside of the GSRP classroom.

Please check on of the responses listed below and sign and date the form in the space provided:

___Yes, I give permission for the screening (s) and/or service (s)

___No, I do not give permission for the screening (s) and/or service (s)

_____

Parent/Guardian Signature **Date**

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GSRP Underage Consideration

****Only complete if your child will turn 4 after September 1 - December 1****

GSRP Underage Eligibility Consideration-Special Circumstances for Children turning 4 **after** September 1st - December 1st.

I understand that a child who turns 4 years old **after** September 1st - December 1st can be considered for enrollment in the Free Preschool in Berrien County by requesting this Special Consideration.

I also understand that the intention of the Great Start Readiness Preschool program is to be provided the year before a child enters kindergarten, therefore I am requesting that eligibility for enrollment into a Great Start Readiness Preschool program be considered for my child because I plan to request early entry into kindergarten the following year.

_____ and _____.
Child's full name Date of Birth

I understand that this does not guarantee my child a classroom placement in GSRP for the school year and that I will be notified of the enrollment status after **September 1.**

_____ _____
Parent Signature Date

These materials were developed under a grant awarded MiLEAP

Teacher: _____

CHILD INFORMATION RECORD

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

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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)	Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)	2nd Phone (if applicable) ( )
City / State / Zip Code		City / State / Zip Code	
Email Address (optional)		Email Address (optional)	
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/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)	

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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 treatment 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 Citation.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

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

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

_____ / /
Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications:

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	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

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

STUDENT TRANSPORTATION INFORMATION FORM
NORTHSIDE SCHOOL ONLY

DATE FORM COMPLETED: _____ COMPLETED BY (PRINT): _____

STUDENT NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ OTHER PHONE: _____

PARENT/GAURDIAN NAME: _____

AM ADDRESS: _____

PM ADDRESS: _____

CHILD CARE PROVIDER NAME: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

SIGNATURE OF PERSON COMPLETING FORM: _____

TRANSPORTATION & SCHOOL OFFICE USE ONLY

New or Existing Student (Circle one) **Student ID:** _____ **Program: GSRP**

Gen or ECSC (Circle one) **AM FULL (Circle one)** **MON-THURS OR MON-FRI (Circle one)**

AM Route: _____ **PM Route:** _____ **Stop Location:** _____

AM Time: _____ **PM Time:** _____ **Processed by:** _____

Driver Notified: ____ **Parent Notified:** ____ **School Notified:** ____ **Date to Start:** _____