Overview and Family Application

for the 2021-2022 School Year

PA Pre-K Counts provides grants from the Commonwealth of Pennsylvania to allow families with children (ages three and four years on or before September 1) to apply for entry in a high quality, Pre-K program ***at no cost to the family for those who qualify***. At Grays Ferry Early Learning Academy, we believe that early education will prepare children to succeed in kindergarten. The Pre-K Counts programs operates on an academic calendar (September – June). ELRC and private pay are accepted for extended care.

Residents of Pennsylvania children who meet the required criteria will be considered for placement in the program. All families must meet the income guidelines to be eligible for the program.

Families who qualify financially and also have secondary at-risk factors (i.e. English as a Second Language, Foster Care, Early Intervention Services, etc.) will be given priority consideration for the program.

To apply for Pre-K Counts, please complete the application. Incomplete applications will not be considered for acceptance into the program.

Thank you for your interest in the Pennsylvania Pre-K Counts Program!

Center location: Grays Ferry Early Learning Academy
1325 S. 33rd Street, 4th Floor
Philadelphia, PA 19146
P: (215) 634-9777 | F: (267) 319-8941

Contact: Unis Bey – unisb@graysferryela.org

Pre-K Counts Checklist

Included in this packet is the application for our Pre-K Counts Program. Please complete the information and return it to the Center.

Incomplete applications will not be reviewed. "Incomplete" is defined as missing any of the supporting documents, failure to sign any part of the application, no phone number listed / number out of service, etc. Thank you for your cooperation in this matter.

Please submit copies of the items listed below with your application:

☐ Completed Application form

☐ Child's birth certificate

☐ Verification of residence

☐ Driver's license or government-issued ID of parent/guardian

☐ One months' worth of most recent pay stubs, W-2 or most current filed 1040 tax form

☐ ELRC acceptance or waiting list letter (*if applicable)*

The following items are due immediately upon acceptance into the program:

☐ Immunization Records

☐ Physical **This includes vision, hearing, and dental screenings. **

2021-2022 PA Pre-K Counts Enrollment Form

Please print clearly

Date Form Completed: _____ / _____ / _____
MM **DD** **YY**

Section 1: Child Information

Last Name (Child)	**First Name (Child)**	**Middle Initial**

Street Address	**County**

City	**State**	**Zip Code**
	PA	

School District of Residence

Home Phone	**Work Phone**	**Email Address**

Child's Date of Birth	**Age**	**Gender**
	☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Male ☐ Female

Race *(optional)*

- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Not Applicable
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Other

Ethnicity *(optional)*

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Not Applicable

Primary Language

- ☐ English
- ☐ Spanish
- ☐ Other _____ (please specify)

Section 2: Parent Information

Name of Parent or Guardian completing this application	**Gender**
	☐ Male ☐ Female

Relationship to Child

- ☐ Father
- ☐ Mother
- ☐ Guardian
- ☐ Other _____ (please specify)

(Select)

- ☐ Biological
- ☐ Foster
- ☐ Adoptive
- ☐ Other _____ (please specify)

Role

- ☐ Primary Guardian
- ☐ Secondary Guardian
- ☐ Legal Guardian
- ☐ Other _____ (please specify)

Section 3: Household Income

List Household Members below for determination of family size *(required)*:

	Relationship to Child	*Age*
1	ENROLLING CHILD	
2		
3		
4		
5		
6		
7		
8		

Per PKC Statute, Regulations, and Guidance, the following members of the household are included in family size:

- Parent of the child (biological or adoptive mother or father, stepmother or stepfather, caretaker or spouse)
- A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
- A child who is 18 years of age or older but under 22 years of age who is enrolled in high school, a general educational development program, or a post-secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent on the income of the parent or caretaker or spouse of the parent or caretaker.
- Others supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program. ***If counted toward family size, any applicable income of these persons must also be counted for eligibility purposes.***

Note: A family size value of one (1) with an income of $0 is entered when a foster child is applying for Pennsylvania Pre-K Counts.

DETERMINED FAMILY SIZE =

Income Verification

2021 Federal Poverty Level Guidelines

Family Size	**100% (Head Start Eligible)**	**300% (Pre-K Counts Eligible)**
1	$12,880	$38,640
2	$17,420	$52,260
3	$21,960	$65,880
4	$26,500	$79,500
5	$31,040	$93,120
6	$35,580	$106,740
7	$40,120	$120,360
8	$44,660	$133,980
Each Additional	+$4,540	+$13,620

Section 4: Employment Information

Employment Status of parent/guardian	Employment Status of 2nd parent/guardian (if applicable)
☐ Employed Full-Time	☐ Employed Full-Time
☐ Employed Part-Time	☐ Employed Part-Time
☐ Unemployed	☐ Unemployed
☐ Other _____	☐ Other _____

Section 5: Household Income

Household Income Sources *(Must check all that apply):*

☐ Employment	☐ Self-Employment	☐ Unemployment Compensation	☐ Worker's Compensation	☐ TANF Cash payments
☐ Social Security	☐ SSI	☐ Child Support	☐ Alimony	☐ Other

Other Child Eligibility Risk Factor Criterion *(Must check all that apply):*

Section 6: Eligibility Risk Factor Criterion

☐	**Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐	**Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services.
☐	**Education Level of Guardian:** Does not have high school diploma or GED or post-secondary degree.
☐	**English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
☐	**Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
☐	**Incarcerated Parent:** A child for whom one of the child's parents is currently in prison.
☐	**Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following: A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.
☐	**Migrant (Non-Immigrant)/Seasonal Student:** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
☐	**Teen Mother:** A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided in this application and the associated income documentation is accurate. I understand that I may be asked to verify or substantiate information provided.

Parent/Guardian (Signature) **Date**

Parent/Guardian Name (Print Name)

For Head Start Eligible families (100% of FPL or below) ☐ **Check if not applicable**

Section 7: Head Start Eligibility

I have been informed of my child's eligibility for Head Start and given the following:

☐ Contact information for the following Head Start location _____
☐ Application and/or assistance with referral
☐ Brochure or website with information about Head Start

My signature below indicates that I have been informed about my options but may still choose to enroll in the Pre-K Counts program.

Parent/Guardian Signature **Date**

Staff Signature **Date**

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME: Grays Ferry Early Learning Academy		
FACILITY PHONE: (215) 634-9777	COUNTY: Philadelphia	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

Date of most recent well visit:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME	BIRTH DATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ____

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip

REPORT OF EXAMINATION

		TOOTH CHART															
		RIGHT								LEFT							
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	UPPER
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	LOWER
	UPPER																	UPPER
	LOWER																	LOWER

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address