

GSRP Preschool Application 2020-2021

These materials were developed under a grant awarded by the Michigan Department of Education

Qualifications for GSRP:

- Your child must be 4 by September 1st of the school year (Consideration for children who turn 4 from September 2nd-December 1st of the year will take place after September 1st)
- You must live in Berrien County (Cross-County families will need to complete a Cross County Prior Approval form: Consideration for Cross-County will take place after September 1st and RESA will seek approval)
- You must meet the income guidelines for your family size stated below within the GSRP columns **OR**
 - If you qualify for Head Start: Please contact Tri-County Head Start at 1-800-792-0366 or www.tricountyhs.org
 - If you qualify for tuition your application will be reviewed on/after September 1st if there are still openings in the GSRP classroom

2020-2021	Head Start	Head Start	GSRP	GSRP	GSRP	Tuition enroll on/after Sept. 1
Household Size	0-50%	51-100%	101-150%	151-200%	201-250%	251-300%
1	0-6,380	6,381-12,760	12,761-19,140	19,141-25,520	25,521-31,900	31,901-38,280
2	0-8,620	8,621-17,240	17,241-25,860	25,861-34,480	34,481-43,100	43,101-51,720
3	0-10,860	10,861-21,720	21,721-32,580	32,581-43,440	43,441-54,300	54,301-65,160
4	0-13,100	13,101-26,200	26,201-39,300	39,301-52,400	52,401-65,500	65,501-78,600
5	0-15,340	15,341-30,680	30,681-46,020	46,021-61,360	61,361-76,700	76,701-92,040
6	0-17,580	17,581-35,160	35,161-52,740	52,741-70,320	70,321-87,900	87,901-105,480
7	0-19,820	19,821-39,640	39,641-59,460	59,461-79,280	79,281-99,100	99,101-118,920
8	0-22,060	22,061-44,120	44,121-66,180	66,181-88,240	88,241-110,300	110,301-132,360
For each additional family member add	2,240	4,480	6,720	8,960	11,200	13,440

What you need to provide:

If you qualify for GSRP, you'll need to provide the following documents to be considered for enrollment. Enrollment doesn't happen on a first come first serve. Enrollment looks at income and risk factors to place children into the classrooms per State of Michigan requirements for GSRP and pending state approved GSRP budget per year.

Turn in the following items with your application packet:

- 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 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 or your county health department where your child was immunized / vaccinated.



GSRP Preschool in Berrien County

School Districts:

Benton Harbor Area Schools

Discovery Enrichment Center
465 S. McCord Street, Benton Harbor MI 49022
269-605-1600 **(Full Day Program) (Transportation within District)**

Benton Harbor Charter School Academy

455 Riverview Drive, Suite 1, Benton Harbor MI
269-925-3807 **(Full Day Program) (Transportation within District)**

Berrien Springs Public Schools

One Sylvester Ave. Berrien Springs MI 49103
269-471-1836 **(Part-Day Program) (Transportation within District)**

Brandywine Community Schools

1620 LaSalle Ave Niles MI 49120
269-684-6511 **(Full Day Program)**

Buchanan Community Schools

109 Ottawa St. Buchanan MI 49107
269-695-8409 **(Part-Day Program) (Transportation within District)**

Coloma Community Schools

262 S. West Street, Coloma MI 49038
269-468-2420 **(Full Day Program) (Transportation within District)**

Eau Claire Public Schools

6238 West Main Street Eau Claire MI 49111
269-461-6191 **(Full Day Program) (Transportation within District)**

Niles Community Schools

Northside Child Development Center
2020 N. Fifth Street Niles MI 49120
269-683-1982 **(Full Day and Part-Day Programs) (Transportation within District)**

Watervliet Public Schools: North Elementary

287 Baldwin Ave, Watervliet MI 49098
269-463-0820 **(Full Day Program)**

Community Based Organizations:

Immanuel Dev Center/Bridgman

9650 Church Street
Bridgman MI 49106
269-465-6031 **(Full Day Program)**

The Children's Center, Niles: Site 1

210 Main Street, Niles MI 49120
269-683-0405 **(Full Day Program)**

The Children's Center, Saint Joseph: Site 2

1000 Minor Road, St. Joseph, MI 49085
1-888-926-0405 **(Full Day Program)**



BERRIEN COUNTY GSRP APPLICATION 2020-2021

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
 Berrien Springs
 Brandywine
 Buchanan
 Coloma
 Eau Claire
 Niles
 Watervliet
 Immanuel Lutheran/Bridgman
 The Children's Center/Niles
 The Children's Center/Saint Joseph

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: \$_____

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



2020-2021 Income/Age/Resident/IEP Verification Form

Berrien County GSRP Program

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

Income Source Verification Documentation provided	Amount Received			
	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: _____

Parent/Guardian Signature: _____ Date of Verification: _____

: CF'C : : 79 I G9'CB@M	
<input type="checkbox"/> Proof of Age: Such as a Birth Certificate, passport, immigration record or baptismal certificate <input type="checkbox"/> 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. <input type="checkbox"/> Proof of Residency: Such as driver's license, rent receipt, utility bill, letter from shelter or host if between homes. <input type="checkbox"/> If a child has an IEP (Individual Education Plan) copy has been reviewed	
GSRP Staff Signature _____	Date of Verification _____



Photo Release Form for GSRP Students

I **give permission** for my son/daughter photo/image to be used. Please complete the form below

I **do not give permission** for my son/ daughter photo/image to be used. However, please complete the Guardian's name and Minor's name sections as well as sign and date the form.

I, _____, give the GSRP school/site, Berrien RESA and its affiliated programs permission to use the photo/image/video of the minor named below and grant the GSRP school/site and Berrien RESA all rights to use these photo/image/video in any medium for educational, promotional, advertising or other purposes that support the mission of the District. I agree that all rights to the photo/image/video belong to GSRP/Berrien RESA.

Guardian's Name: _____

Minor's Name: _____

Parent/Guardian's Signature: _____

Date: _____

Address: _____

Phone: _____

Email: _____



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



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

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?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	
			<i>Parent/Guardian Signature</i> _____ Date	

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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Height Weight Other: _____					
			Muscle Imbalance											
			Other: _____											
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT	⇨				
			Other: _____											
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / / Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm					
			Albumin											
			Microscopic											
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			Influenza (IIV/LAIV)	1
DTaP/DTP/DT/Td	1	4	2		4
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6		2	
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3		2	
	2	4		OTHER Vaccines Specify Date & Type	
Polio (IPV/OPV)	1	3	1	Type of Vaccine(s)	Date of Vaccine(s)
	2	4	2		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Rotavirus (RV1/RV5)	1	3	*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.		
	2				
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
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	
<input type="checkbox"/>	<input type="checkbox"/>	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:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> 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: _____

_____ / _____ / _____
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.

