Preschool Enrollment Packet

POTENTIAL
DEVELOPMENT
Creating Brighter Futures for Students with Autism

880 E. Indianola Avenue
Youngstown, OH 44502
(330) 746-7641

Please use this check list to ensure that you are returning a completed enrollment packet. Missing or incomplete information may delay entry into the program.

☐ Potential Development Application

☐ ODJFS Child Enrollment and Health Information

☐ Alta Head Start Child Medical Statement

☐ ODJFS Child and Adult Care Food Program Enrollment Form

☐ Child and Adult Care Food Program: Income Eligibility Application

☐ Parent/Guardian Request for Fluid Milk Substitution

☐ Authorization for Occupational Therapy Screening and Evaluation

☐ Phone Call System Contact Form

☐ Picture and Name Release – Class List release

☐ Authorization for Assessment/Authorization for Hearing Screening

☐ Authorization to Obtain Information

☐ Consent for Records Request

☐ Authorization for Release of Information

☐ Parent/Guardian Agreement Form

☐ Potential Development Preschool Fee for Services

☐ Transportation/Emergency Contact Information

☐ Potential Development Family Handbook

POTENTIAL
DEVELOPMENT
Creating Brighter Futures for Students with Autism

Date________________________________

GENERAL INFORMATION

Student's Name__________________________________ ____
(First) (Last)

Student's Address____
(Street)

____
(City, State, Zip)

Home Telephone Number____

Student's Gender ________Female ________Male

Student's Date of Birth ________________ ______________ _____________
(Month) (Date) (Year)

FIRST PARENT/GUARDIAN INFORMATION

Last Name_____________________________________ First Name___________________________________

Relationship to Student____

Address____
(Street)

____
(City, State, Zip)

Home Phone Number_______________________ Cell Phone Number _________________________________

Place of Employment____

Work Address____
(Street)

____
(City, State, Zip)

Work Hours_______________________________________ Title____

Work Phone Number____

SECOND PARENT/GUARDIAN INFORMATION

Last Name____ First Name_______________________________________

Relationship to Student____

Address____
(Street)

____
(City, State, Zip)

Home Phone Number____________________________ Cell Phone Number __________________________________

Place of Employment____

Work Address____
(Street)

____
(City, State, Zip)

Work Hours_____________________________________ Title____

Work Phone____

BIRTH/DEVELOPMENTAL HISTORY

Length of Pregnancy? ☐ 6 ☐ 7 ☐ 8 ☐ 9 months

Child's Weight at Birth __________lbs. ________ounces

Were there any unusual factors or complications during this pregnancy? ☐ yes ☐ no

Please Describe: ____

Which doctor is most familiar with your child? ____

Doctor's phone number____

Does your student take any medications on a regular basis? ☐ yes ☐ no

If yes, name of medication and dosage: ____

Has your student had any of the following illnesses (dates)?

________ measles	_______ rheumatic fever	________ mumps
________ chicken pox	_______ whooping cough	________ pneumonia
________ middle ear infection	_______ hepatitis	________ meningitis

Were there any complications with these illnesses, such as high fever, convulsions, muscle weaknesses, and so on?

☐ yes ☐ no Please describe: ____

____

Has the student ever been hospitalized? ☐ yes ☐ no

Number of times__________ Total length of time______________________________

Reasons: ____

____

Has the student had any other serious illness or injuries that did not involve hospitalization?

☐ yes ☐ no Please describe: ____

Does the student have:

Allergies? ☐ yes ☐ no (Please specify which allergies):

Foods____

Animals____

Medicine____

Asthma? ☐ yes ☐ no

Hay Fever? ☐ yes ☐ no

Do you have any concerns about your child's speech or language development? ☐ yes ☐ no

If yes, describe: ____

____

Does the student do some things that you find troublesome? ☐ yes ☐ no Please describe: ____________

____

____

Has your child had any problems with earaches or ear infections? ☐ yes ☐ no

If yes, how often in the past year? ____________________________________

Has your child's hearing been tested? ☐ yes ☐ no Date of test ____________ ____________

(month) (year)

Was there evidence of hearing loss? ☐ yes ☐ no If yes, describe: ____________________________________

____

Does your child currently have tubes in his/her ears? ☐ yes ☐ no

Do you have any concerns about your child's speech or language development? ☐ yes ☐ no

If yes, describe: ____

____

Has your child's vision been tested? ☐ yes ☐ no Date of test: _______________ ______________
(month) (year)

Has there any evidence of vision loss? ☐ yes ☐ no Please describe: ________________________________

____

Does your child do some things that you find troublesome? ☐ yes ☐ no Please describe:___________________

____

Has your child ever participated in out-of-the-home childcare services, for example, sitter, day care, preschool?

☐ yes ☐ no Please describe: ____

CHILD'S PLAY ACTIVITIES

Where does your child usually play, for example, backyard, kitchen, bedroom?

____

Does your child usually play: _______alone ______with one to two other children? _____with brothers/sisters?

_____with older children? _____with younger children? _____with children of the same age?

Is your child usually _______cooperative? _______shy? _______aggressive?

What are some of your child's favorite toys and activities?____

______________________ ____

Are there any particular behaviors you would like us to watch?____

____

CHILD'S DAILY ROUTINE

Do you have any concerns about your child's:

__________eating habits?

__________sleeping habits?

__________toilet training?

If yes, please describe: ____

Is your child toilet trained? ☐ yes ☐ no

If yes, how often does your child have an accident? ____

What word(s) does your child use or understand for:

urination____________________ bowel movement____________________

How many hours does your child sleep?

At night? _______ Goes to bed at: ________P.M. Wakes up at: ________A.M.

Afternoon nap: _________

Describe any problems with sleep patterns____

____

When your child is upset, how do you comfort him or her? _______________________________

____

____

The term family has many different meanings. Since the topic of families and family members is often included in classroom discussions, please list or describe whom your child considers to be "family" at home.

____

____

How many brothers and sisters does your child have?

Brothers (ages):___________________ Sisters (ages):_______________

___________________ _______________

___________________ _______________

What language(s) is/(are) most commonly spoken in your home?

English________________________ Other_________________________

Is there any additional information that would help us understand or work more effectively with your child?

____

____

____

____

____

Additional Emergency Contacts

Child's Name:____________________

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

Name	Address
City	State
Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)	

ALTA HEAD START/EARLY HEAD START DEMOGRAPHICS

Adults – Enter Primary Adult First										
Code	First	M.I.	Last	D.O.B.	Sex	Race	Education Level	Empl. Status	Prim. Lang.	Eng. Prof.
A01				/ /	☐M ☐F					
A02				/ /	☐M ☐F					

Education Level Codes
G9 = 9th Grade
G10 = 10th Grade
G11 = 11th Grade
G12 = 12th Grade, no diploma
GED=General Ed. Diploma
HSG = High School Graduate
COL = Some College
CTG = College Degree

Employment Status Codes
B = Full Time Work & Training
L = Part Time Work & Training
R = Retired/Disabled
P = Part Time
S = Seasonal
U = Unemployed
F = Full Time
T = Training School

Race
B= Black/ African American
H= Hispanic
MR= Biracial/Multi-Racial ________
W= White
Other ________

English Proficiency
0 = None
1 = Poor
2 = Moderate
3 = Proficient

Parental Status: ☐ One ☐ Two ☐ Foster ☐ Teen
Non-Parent (explain) ________ Other Arrangement (explain) ________

Number of children ________ By age: 0 – 3 ________ 4 – 5 ________

Number in Family:

Number in Household:

Code	First	M.I.	Last	D.O.B.	Sex	Race	Related to	How Related	Status Codes	Prim. Lang.	Eng. Prof.
C01				/ /	☐M ☐F						
C02				/ /	☐M ☐F						
C03				/ /	☐M ☐F						
C04				/ /	☐M ☐F						
C05				/ /	☐M ☐F						

Related to Codes
B12 = Both Adults
A01 = Primary Adult
A02 = Second Adult, etc.

How Related
C = Natural Child
G = Grandchild
N = Niece / Nephew
F = Foster
O = Other ________

Status Codes for participation
A = Applied Child
N = Next Year Eligible
Y = Too Young
O = Too Old

English Proficiency
0 = None
1 = Poor
2 = Moderate
3 = Proficient

Enrollment Comments: ____

Code	First	M.I.	Last	D.O.B.	Sex	Race	Education Level	Empl. Status	Prim. Lang.	Eng. Prof.
Other				/ /	☐M ☐F					

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Center

Home Address	City

State	Zip Code	Home Telephone Number

Parent/Guardian Name	Relationship to Child
Home Address	Home Telephone Number

City	State	Zip

Email Address *(if applicable)*	Cell Phone
Parent's Work/School Telephone Number	Parent's Work/School Name
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Parent/Guardian Name	Relationship to Child
Home Address	Home Telephone Number

City	State	Zip

Email Address (if applicable)	Cell Phone
Parent's Work/School Telephone Number	Parent's Work/School Name
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			***Do Not Give Permission* to Transport**	
Center or Type A Home Name		**OR** **Do not sign both**	Center or Type A Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth
☐ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.	
Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

	PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES *check all that apply for each disease*		
Diseases for Immunization	**Immunized**	**In Process of Immunization**	**Medically Contraindicated/ Not Age Appropriate**
Chicken pox	☐	☐	☐
Diphtheria	☐	☐	☐
Haemophilus influenzae type b	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Influenza ☐ Seasonal Vaccine Not Available	☐	☐	☐
Measles	☐	☐	☐
Mumps	☐	☐	☐
Pertussis	☐	☐	☐
Pneumococcal disease	☐	☐	☐
Poliomyelitis	☐	☐	☐
Rotavirus	☐	☐	☐
Rubella	☐	☐	☐
Tetanus	☐	☐	☐

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent	Date of Signature

Recommended Assessments/Screenings			
Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements:		**Notes:**
Height		
Weight		
BMI		

CACFP
ENROLLMENT FORM

Requirements:

a. CACFP child care centers and Head Start centers must have a completed CACFP Enrollment Form on file for each enrolled child. Siblings must have a separate form as attendance may be different.

b. The CACFP Enrollment Form is valid for 12 months following the month of parent/guardian dated the form. For example: Parent dated the form on 7/13/2016; form would expire on 7/31/2017). CACFP Enrollment forms must be completed annually by parent/guardian.

c. The following CACFP program types DO NOT need CACFP Enrollment forms:
    - Outside-School Hours Centers
    - Youth Development Programs
    - After School At Risk Programs
    - Emergency Shelters

Enrollment Form Reminders

- List one child per form
- All parts of form to be completed by parent/guardian including normal days, hours and meals
- If parent/guardian work schedule varies frequently thus the child's attendance pattern will also change frequently then parent should check the box at the bottom of the chart. Parent/guardian is not required to complete another form but may elect do so.
- For ease of collection, it is highly recommended that agencies/centers distribute enrollment forms to parents/guardians at the same time as the Income Eligibility Application so that it is more likely that the forms would expire on the same date.
- If sponsor decides to develop own CACFP enrollment form, form contain all required information and be approved by State Agency prior to use.

ATTACHMENTS

- State Agency Prototype CACFP Enrollment Form
- Example of completed CACFP Enrollment form

Ohio Department of Education - Office for Child Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME (please print)	**AGE**	**BIRTHDATE** / / month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ **Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule**

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**
MAILING ADDRESS: STREET /APT.	**CITY**	**ZIP CODE**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider. (rev. 12/3/2015)

PARENT/GUARDIAN REQUEST FOR FLUID MILK SUBSTITUTION

Parents or guardians may now request in writing that non-dairy beverages be substituted for fluid milk for their children with special dietary needs without providing statement from a recognized medical authority. However, fluid milk substitutions requested are at the **option** and expense of the facility/center.

The non-dairy beverage provided must be nutritionally equivalent to fluid milk and meet the nutritional standards set by the United States Department of Agriculture (USDA) for Child Nutrition Programs in order for the facility/center to claim reimbursement for the meal through the Child and Adult Care Food Program (CACFP).

A non-dairy beverage product must at a minimum contain the following nutrient levels per cup to qualify as an acceptable milk substitution:		
a. Calcium 276 mg b. Protein 8 g c. Vitamin A 500 IU	d. Vitamin D 100 IU e. Magnesium 24 mg f. Phosphorus 222 mg	g. Potassium 349 mg h. Riboflavin .44 mg i. Vitamin B-12 1.1 mcg

To be completed by Child Care Center/Provider prior to distribution of form	
Name of Child Care Center/Provider:	
	This child care center/provider will provide the following non-dairy beverage which meets the USDA approved nutrient standards for a milk substitute: (list substitute(s))
	This child care center/provider has chosen not to provide non-dairy beverages for the substitution of fluid milk.

To be completed by Parent/Guardian	
Child's Full Name:	
Identify the medical or other special dietary need that restricts the diet of your child (why your child needs a non-dairy beverage as a milk substitute):	
	I request that my child is served the non-dairy beverage which meets the USDA approved nutrient standards for a milk substitute that is provided by the center/provider as indicated above.
	I am aware that the center is not providing a non-dairy beverage for the substitution of fluid milk. I will provide a non-dairy beverage for my child that meets the USDA approved nutrient standards for a milk substitute as stated above.
	I will provide a non-dairy beverage for my child that does **not** meet the USDA approved nutrient standards for the substitution of fluid milk. I understand that the center cannot claim meals that require milk unless I get written statement from a recognized medical authority.
Signature of Parent/Guardian:	**Date:**

NON-DISCRIMINATION STATEMENT: The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

POTENTIAL
DEVELOPMENT
Creating Brighter Futures for Students with Autism

AUTHORIZATION FOR THERAPY SCREENING/EVALUATION

Student Name:_______________________________ D.O.B.___________

I____, give my consent for the above student
parent name (print)

name to be seen by an Occupational Therapist, Speech Therapist and/or Physical Therapist from Potential Development for a full screening and evaluation. If my child needs any of the therapies listed above in order to receive the best quality of education possible and to meet the individual needs of my child, I give permission for my child to receive Occupational, Speech and/or Physical Therapy Services.

Signed:______________________________________ Date:_____________

Witnessed by:_________________________________ Date:_____________

INCOME CHART FOR THERAPY SERVICES

(Occupational, Physical and Speech Therapies)

Please indicate what category best describes your family situation. This information will be kept confidential.

Household Size	Free	Reduced	Paid
1	0-$13,250_______	$13,520-$19,240_______	$19,240-Over_______
2	0-$18,200_______	$18,200-$25,900_______	$25,900-Over______
3	0-$22,880_______	$22,880-$32,560_______	$32,560-Over______
4	0-$27,560_______	$27,560-$39,220_______	$39,220-Over______
5	0-$32,240_______	$32,240-$45,880_______	$45,880-Over______
6	0-$36,920_______	$36,920-$52,540_______	$52,540-Over______
7	0-$41,600_______	$41,600-$59,200_______	$59,200-Over_______
8	0-$46,280_______	$46,280-$65,860_______	$65,860-Over_______

For each additional family member add

Free $4,680 Reduced $6,660

Parent Signature_______________________________________ Date________________________

Dear Parent/Guardian

In an effort to ensure that families are kept up-to-date on school events, closings and other important information, we use the One Call Now automated calling system. The system can leave a message on the cell phone (s) or home phone(s) of your choice. Please list at least one phone number where a message can be left regarding school notifications.

Student Name: ____

Phone number #1: ____

Phone number #2: ____

Email address: ____

Do you prefer to be contacted by:

☐ Phone ☐ Cell Phone ☐ Email

POTENTIAL DEVELOPMENT

Creating Brighter Futures for Students with Autism

CONSENT FOR RECORDS RELEASE

Date: ____________________________

Child's Name:_____________________________________

Age:_______________

Date of Birth:______________________________________

RECORDS MAY INCLUDE: Check all that apply

_____ Transition Form

_____ Attendance Records

_____ Health and Immunization Records

_____ Health and Development Assessments

_____ IEP/ETR

_____ Other

I authorize Potential Development Preschool Program to release the above listed records regarding

_________________________________. I authorize Potential Development to consult with the school district

of enrollment concerning my child's records.

____ _______________________

Signature of Parent/Guardian Date

880 E. Indianola Avenue, Youngstown, OH 44502 (330)746-7641 fax: 330-746-4008 website: potentialdevelopment.org

POTENTIAL DEVELOPMENT
Creating Brighter Futures for Students with Autism

PICTURE AND NAME RELEASE

Child's Name ____

On occasion, pictures are taken of the children, either individually or in a group.

I, the undersigned, consent that photographs may be taken and the name of this child may be used for newspaper or other media as part of Potential Development Program, Inc.

Signed____ Date________________________

Witnessed by _____________________________________ Date________________________

I **do not** consent to the above statement.

Signed____ Date________________________

CLASS LIST

I, the undersigned, consent to have my name and telephone number included on the class list to be distributed, upon request, to the parents of children in my child's class.

Signed____ Date________________________

Witnessed by_____________________________________ Date________________________

I **do not** consent to the above statement.

Signed____ Date________________________

Witnessed by_____________________________________ Date________________________

POTENTIAL DEVELOPMENT

Creating Brighter Futures for Students with Autism

Child's Name________________________________ Date of Birth____________

AUTHORIZATION FOR ASSESSMENT

I, the undersigned, give my consent for the above named child to be evaluated by a psychologist at Potential Development Program. The purpose of the evaluation is to gather information to develop an educational program in order to best meet the individual needs of my child.

Signed by_________________________________ Date_________________

Witnessed by______________________________ Date_________________

AUTHORIZATION FOR HEARING SCREENING AND TYMPANOGRAM

I, the undersigned, give my consent for the above named child to be seen by an audiologist from Youngstown Hearing and Speech Center for semi- annual hearing screenings and/or tympanograms.

Signed by________________________________ Date_______________

Witnessed by______________________________ Date_____________

POTENTIAL DEVELOPMENT

Creating Brighter Futures for Students with Autism

AUTHORIZATION TO OBTAIN INFORMATION

Potential Development is hereby granted permission
to obtain information from:

____

____

____
Name, Address, Institution or Agency

______________________________ ____________________ ________________
Student Date of Birth Social Security #

Purpose of need for disclosure: To aid in educational planning

Specific information to be disclosed:

______Medical ______Developmental Records

______Educational ______Speech/Language Evaluation

______Psychological Evaluation ______Other (specify)

THIS CONSENT (UNLESS EXPRESSIVELY REVOKED EARLIER) EXPIRES 90 DAYS FROM SIGNATURE DATE BELOW:

____________________________________ ________________________________
Legal Guardian Witness

____________________________________ ______________
Relationship to Student Date

POTENTIAL DEVELOPMENT

Creating Brighter Futures for Students with Autism

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, give my permission for Potential Development Program to release information pertaining to diagnosis and treatment and/or related contacts of:

Name________________________________ Date of Birth______________________

Address____

To agency(s) or individual(s) indicated:

Check

[ ] Public Schools

[ ] Hine Information & Referral

[ ] Children Services Board

[ ] Other (Doctor)

Evaluation Reports on your child are available for review by parents or legal guardians.

Signed by_______________________________ For___________________________

Witnessed by____________________________ Date__________________________

PARENT/GUARDIAN AGREEMENT FORM

The success of our program for your child depends upon the ability of the staff and parents to work together to meet each child's unique needs.

We expect that you will:

- Have your child attend the program regularly and on time.
- Keep your child home if he/she is ill.
- Phone the office and transportation each day if your child will be absent.
- Dress your child in comfortable clothes and shoes that are suitable for climbing.
- Label all of your child's possessions, such as clothing, book bags, etc.
- Send an extra set of clothes to keep at the school. This set should include pants, shirt, underwear and socks.
- Provide a book bag for your child to bring every day.
- Send a supply of diapers and wipes if your child is not toilet trained.
- Attend parent conferences regularly.
- Keep staff immediately informed of any change in phone number or address.
- Keep staff immediately informed of medical concerns or visits.

I agree to be involved in my child's school by attending scheduled conferences and parent group meetings.

__________________________________ ____________________
Parent/Guardian signature Date

__________________________________ ____________________
Witness Date

PRESCHOOL RATE

The fee schedule for Potential Development Program is based on income and family size. No client pays the full cost of service thanks to the support of the United Way of Youngstown and the Mahoning Valley.

Poverty level $16,450.00

Income			Fee
$16,450	through	$18,999	$53.00
$19,000	through	$21,999	$79.00
$22,000	through	$24,999	$106.00
$25,000	through	$27,999	$132.00
$28,000	through	$30,999	$158.00
$31,000	through	$34,999	$185.00
$35,000	through	$37,999	$198.00
$38,000	through	$40,999	$211.00
$41,000	through	$43,999	$224.00
$44,000	through	$46,999	$238.00
$47,000	through	$49,999	$251.00
$50,000	through	$54,999	$264.00
$55,000	through	$59,999	$297.00
$60,000	through	$64,999	$330.00
$65,000	through	$69,999	$396.00
$70,000	through	$74,999	$462.00
Over $75,000			$495.00

For each dependent above a family of four, a one step reduction is made according to the above scale, your fee

for enrolling________________________________ in the program will be ____________________per month.

I/we agree to pay the sum of ______________per month. Effective___________________

Witness_________________________________ Signature_________________________________

Date__________________________

The fee for services is due on the 1st of the month. Fees may be mailed in or paid in our front office. As stated in our parent information booklet, the non-payment of fees is cause for termination of services.

880 E. Indianola Ave., Youngstown, OH 44502 (330) 746-7641 fax: (330)746-4008

POTENTIAL DEVELOPMENT

Creating Brighter Futures for Students with Autism

TRANSPORTATION/EMERGENCY CONTACT INFORMATION

Student's Name____

The following individuals are authorized to transport the above named child from the Potential Development Preschool, 880 E. Indianola Avenue, Youngstown, OH 44502

______________________________	______________________________
Name	Name
______________________________	______________________________
Address	Address
______________________________	______________________________
Phone Number	Phone Number
______________________________	______________________________
Relationship	Relationship

______________________________	______________________________
Name	Name
______________________________	______________________________
Address	Address
______________________________	______________________________
Phone Number	Phone Number
______________________________	______________________________
Relationship	Relationship

Signed____ Date____

Witnessed by__________________________________ Date______________________________________

POTENTIAL DEVELOPMENT

Creating Brighter Futures for Students with Autism

Parent/Guardian Consent to Share Information and Access Medicaid
The Ohio Medicaid School Program
Potential Development Program

Potential Development Schools has the opportunity to receive Federal Medicaid dollars through a program called the Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for services such as Speech, Audiology, Physical Therapy, occupational Therapy, Nursing, Psychology, Counseling and Social Work services. The district can received Medicaid funding when a student receives one or more of these services and the students has current Medicaid Insurance coverage. In the process of billing Medicaid for these services, certain billing information must be shared with the Ohio Department of Jobs and Families Services. Before the district can submit claim data for Medicaid billing purposes, we must first obtain a signed Parental Consent to Share Information and Access Medicaid.

Your consent is voluntary. You have the right under 34 CFR Part 99 and Part 300 to withdraw your consent at any time. You are not required to enroll in Medicaid. Billing Medicaid will not require you to incur any out-of-pocket expenses such as a deductible or co-pay, decreased lifetime coverage, increase premiums or lead to the discontinuation of benefits, or result in you paying for services that would otherwise be covered by Medicaid. No matter whether you grant consent, refuse consent or revoke consent your child will be provided with an evaluation and/or services listed in their IEP at no cost to you.

☐ I understand and agree to give permission to Potential Development Program to share my child's IEP records in order to bill Medicaid

☐ I do not give permission to Potential Development to share my child's IEP records in order to bill Medicaid.

______________________________ ______________
Student's Full Name Date of Birth

______________________________ ______________ ______________
Parent/Guardian Name (Print) IEP Meeting Date IEP Expiration Date

______________________________ ______________
Parent/Guardian Signature Date

For specific questions regarding the Medicaid Parental Consent, please contact
Healthcare Billing Services, Inc. at (740) 653-6711 or at TeamHBS@aol.com