

Please Return to:
Muskingum Valley Preschool
1605 Airport Rd
New Lexington, OH 43764
P: 740-343-0680 F: 740-343-0683
Email: enrollment@mvesc.org

Required Registration Documents:

Enrollment Packet:

- Preschool Enrollment**
 - Internet Accessibility Survey**
 - JFS Child Care Assistance Application**
(required for all applicants regardless of income, due to preschool offered in conjunction with JFS)
 - Emergency Medical Release Form (green)**
 - Permission Form (blue)**
 - Child Medical Statement (pink)**
 - Dental Exam Form (yellow)**
-

Additional REQUIRED Documents:

- Birth Certificate (copy)**
- Custody/legal documents pertaining to child (if applicable)**
- Immunization Records**
- Proof of Residency**
- Income** (Earned income = 4 weeks of paystubs/Unearned income = Examples: Child support letter, Social Security Award Letter)

All forms must be completed in full and are required for all students enrolling.

Priority Enrollment will run from 3.1.26 - 6.1.26

Any applications after 6.1.26 will be held for secondary enrollment.

Secondary Enrollment will open 7.1.26

Students will be placed on rosters based on availability.

Enrollment will be processed as quickly as possible upon receipt.

***Enrollment will not be processed until ALL required documents have been returned!**
(excluding medical & dental forms)

Please Return to:
 Muskingum Valley Preschool
 1605 Airport Rd
 New Lexington, OH 43764
 P: 740.343.0680 F: 740.343.0683
 E: enrollment@mvesc.org

Office Use Only
 Date Received: _____
 JFS Approval Date: _____
 IEP: _____
 Tuition: _____

Preschool Enrollment

Location: (Select One)

Preferred Days:

New Lexington:	Panther Cub Academy	New Lexington	Junction City	2 (T/Th)	3 (M/W/F)	5 (M-F)
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Northern Local: (all classes are 2 full days per week)	Somerset	Sheridan MS (Glenford)	Thornville	M/T	Th/F
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Southern Local: (all classes are 4-day M/T/Th/F)	Millcreek Elementary	M/T/Th/F
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Full Name: _____ County: _____
First Middle Last

Birthdate: ____/____/____ Gender: M F School District: _____
Month Day Year (you reside in)

Birth City: _____ Ethnicity: Asian American Black Hispanic White Other: _____
(Circle all that apply) Indian

Household Income: _____ Family Size: _____ Mother's Maiden Name: _____

Primary Household that preschooler lives in:

Parent's Name(s): _____
Circle Relationship to student Grandparent Mother Father Stepparent Foster
 Legal Guardian(s) Other: _____

Address: _____
Street Address PO Box (If applicable) City State Zip

Phone(s): _____ Email(s): _____

Secondary Household that preschooler lives in: (Skip if not applicable)

Household Income: _____ Family Size: _____

Parent's Name(s): _____
Circle Relationship to student Grandparent Mother Father Stepparent Foster
 Legal Guardian(s) Other: _____

Address: _____
Street Address PO Box (If applicable) City State Zip

Phone(s): _____ Email(s): _____

Parent/Guardian Signature

Date

OVER →

Tell us about your child

Nickname/Preferred Name _____

Siblings (Names & Ages): _____

Pets (Names & type): _____

What is your child's favorite color? _____ favorite activity? _____

Circle all that describe their personality: Shy Outgoing Playful Inquisitive Talkative Sneaky Cooperative

Creative Curious Defiant Demanding Perfectionist Strong-willed Moody Easily Distracted Bossy Loving Cautious

Do they have any habits (e.g. nail biting, thumb sucking, etc.) _____

How do they react to frustration? _____

What makes them angry? _____

How do they react when angry? _____

How do they respond to discipline? _____

What are your expectations for them at preschool? _____

What skill would you like them to learn? _____

How do you want to participate in their preschool experience? Talent (share) Field Trips Celebrations
Prep materials Other: _____

Is your child toilet trained? Yes No

Do you have any concerns about your child's ability to do any of the following?

Speak Understandably Use complete sentences Answer simple questions Hold a pencil/crayon/or other writing tool

Sit unsupported Walk up or down stairs Other: _____

Does your child have an IEP? Yes* No *Explain:

Has your child received services for a diagnosed disability? Yes No If so, where?

Is there anything else we should know about your child? _____

Student Full Name: _____ Date: _____

Internet Accessibility Survey

(please mark only the box which best describes your student's connectivity for each question)

Connectivity at home

- The student has broadband connectivity (cable, DSL, or non-cellular)
- The student has a cellular hotspot or phone
- The student does NOT have any access to either listed above

Student device access at home

- The student has a computer provided by the school
- The student has a computer provided by self/family
- The student has a smartphone provided by self/family
- The student does NOT have any of the devices listed above

Student's Parent Military Status

- The student has at least one parent on active duty in either the Army, Navy, Air Force, Marines, or Coast Guard
- The student has at least one parent on active duty with the National Guard
- The student has at least one parent on active duty with the Reserves
- The student does NOT have at least one parent in any of the above situations

Ohio JFS Form 07200 – Child Care Assistance

How to Complete It for Preschool Registration

Ohio JFS Form 07200 (Request for Cash, Food, and Medical Assistance) is required for **all preschool enrollment applications regardless of qualification.**

Completing this form allows the State of Ohio to determine whether your child qualifies for the **Early Childhood Education (ECE) Grant**, which provides tuition assistance for eligible preschool families. It is also being used for state compliance with preschool registration.

Even if you are unsure whether you qualify, you must complete and submit this form as part of the preschool enrollment process.

Why This Form Is Required

- It verifies family income.
- It determines eligibility for the ECE Grant.
- It ensures compliance with state preschool funding requirements.
- It must be on file for every preschool applicant.

Incomplete forms may delay enrollment or grant approval.

Sections Most Important for the ECE Grant Application

While the entire form should be completed accurately, the following sections are especially important for ECE funding:

◆ Household Information

- List **all individuals living in the home**, including adults and children.
- Include full legal names and dates of birth.
- This determines household size, which is used to calculate income eligibility.

◆ Income Information (Very Important)

- Report **all sources of gross income** for every adult in the household.
- Include wages, self-employment income, child support, SSI, unemployment, etc.
- Provide current income amounts (before taxes).
- Attach required documentation (pay stubs, benefit letters, etc.).

⚠ Income information is the primary factor used to determine ECE Grant eligibility.

◆ Signature and Date

- The application must be signed and dated.
 - Unsigned forms cannot be processed.
 - Electronic or written signatures must follow the instructions on the form.
-

Helpful Tips When Completing the Form

- Use parent or guardian **legal name** as it appears on official documents as applicant.
 - Answer every question. If something does not apply, write “N/A.”
 - Double-check income totals for accuracy.
 - Include all required supporting documents.
 - Return the completed form with your preschool registration packet.
-

What Happens Next?

After submission:

1. The form will be reviewed by Preschool Office and only forwarded to Job & Family Services based on qualifying factors. Non-qualifying applications will remain in student file for compliance purposes only.
 2. Income eligibility for the ECE Grant will be determined.
 3. Families will be notified if additional documentation is needed.
 4. Preschool staff will be informed of grant approval status.
-

Questions?

If you need assistance completing Ohio JFS Form 07200, please contact the preschool office for support. Staff are happy to help walk you through the process.

Perry County Job & Family Services Contact:



Chelsie Schultheis, *Workforce Supervisor*

PERRY COUNTY JOB & FAMILY SERVICES

5250 State Route 37 E, New Lexington, Ohio 43764

Phone: (740) 503-0750

Email: Chelsie.Schultheis@jfs.ohio.gov

Perryjfs.org



OhioMeansJobs

Perry County
Public Agency of the
Commonwealth of Ohio

SNAP, CASH, MEDICAL, AND/OR CHILD CARE ASSISTANCE APPLICATION

Voter Registration Application Attached - Assistance Available

If you are **NOT** registered to vote where you live now, would you like to apply to register to vote here today?

Yes - I want to register to vote.

No - I do **NOT** want to register to vote.

If you do not check either box, you will be considered to have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

1: Check the box for each program the applicant wants to apply for

You can apply for any and all of the programs listed below. If you do not check any boxes, we will only review your eligibility for SNAP.

- SNAP
 Child Care Assistance
 Medical Assistance
 Cash Assistance - For families with a minor child(ren) or women who are pregnant
 Refugee Cash Assistance (RCA) - For refugees within 12 months of arrival

Step 2: Tell us about the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

First Name	Middle Initial	Last Name
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Do you need any of the following services? <input type="checkbox"/> Large Print Notices <input type="checkbox"/> Sign Language Interpreter <input type="checkbox"/> Translator <input type="checkbox"/> Other _____	What is your preferred language? Spoken: _____ Written: _____
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Have you, or anyone living with you, ever received SNAP, Cash, Medical, or Child Care Assistance?

No
Location (City/County/State): _____

Yes - If yes, who: _____

Step 3: Tell us how to reach the applicant

If you are an Authorized Representative, enter information about the person you are applying for.

Home Address	<input type="checkbox"/> Check here if you do not have a permanent address - please provide a mailing address		
City	State	Zip Code	
Phone (Cell)	Phone (Home)	Email Address	
Address where you get mail (if different)			
City	County	State	Zip Code



Reminder: Did you tell us which program(s) the applicant is applying for?
Make sure to check the appropriate box(es) in Step 1.

Step 4: Tell us if you are an Authorized Representative

An Authorized Representative is someone who helps the applicant with the application process and can act on the applicant's behalf. **If you are filling out this form as an Authorized Representative, please give us the following information about yourself. You may be asked to give an authorization document. You will not be listed as an Authorized Representative until the document is provided.**

First Name	Middle Initial	Last Name
Street Address		
City	State	Zip Code
Phone (Cell)	Phone (Home)	
Email Address		

Do you need any of the following services?

- Large Print Notices Sign Language Interpreter
 Translator Other _____

What is your preferred language?

Spoken: _____
Written: _____

Step 5. For SNAP Applicants and SNAP Authorized Representatives ONLY

By signing below, you agree that you have **reviewed and agree to the terms in Step 14** and you certify, under penalty of perjury, the truth of the information contained in this application, including information provided below concerning citizenship and alien status of the members applying for benefits.

While you may submit your application with only the information provided above, your application may be processed more quickly if you continue to provide responses to the questions below.

 Signature of Applicant OR Authorized Representative	Date
Print Name of Applicant OR Authorized Representative	Date

Step 6: Answer the following ONLY if applying for SNAP benefits

How many people live with you and buy, fix, and eat meals with you? _____

This number is considered your "household", keep this in mind when answering the next two questions.

Note: Your responses will help us decide if you can get SNAP more quickly. If someone else you live with is already receiving SNAP benefits, you may still be eligible for SNAP benefits.

Is your household's total gross income before taxes for the current month less than \$150? Yes No

Is your household's total net income for the current month zero after taxes and paying for such things as housing costs, child/dependent care costs, or child support payments? Yes No

Are your total resources in cash, checking, and savings accounts \$100 or less? Yes No

Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes? Yes No

Are you a migrant or seasonal farm worker? Yes No

Step 7: Tell us the applicant's information

You must list everyone who lives with you even if they are not applying. Please be sure to list your name first. If you need more space, write your answers on an extra piece of paper and attach it to this form. Please use the following to assist with completing the section below:

- **Social Security Number (SSN):** If you, or anyone else in your household, is NOT a U.S. citizen, or a Qualified Non-Citizen, you do not have to give us an SSN. If there are other reasons that you, or someone in your household does not have an SSN, please write that below. (ex: pending SSA application)
- **U.S. Citizen:** You only have to tell us if someone is a U.S. citizen if they are for SNAP, Cash, Medical, or Child Care Assistance.
- **Race/Ethnicity:** Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic (Hispanic or Latino) information. Providing this information is voluntary and is used for informational purposes only. If you do not want to give us this information, it will have no effect on your case.

Name	Relationship to You <small>(spouse, friend, etc.)</small>	SSN <small>(See instructions above)</small>	Date of Birth	Sex	U.S. Citizen	Hispanic or Latino	Race
	Self			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Are you married? No Yes - If yes, spouse's name: _____

Are you, or anyone you are applying for, pregnant?
 No Yes - If yes, who and when is the due date? _____

Do you, or anyone you are applying for need in-home care or nursing home services?
 No Yes- If yes, who? _____

Are you or anyone in your household caring for a disabled person in or outside of the home?
 No Yes - If yes, who? _____

Are you or anyone in your household in the military?
 No Yes - If yes, please select all that apply: Active Duty National Guard/Reserves

Have you ever been found guilty of Child Care fraud? No Yes

Step 8: Household members 60 years of age or older

Is anyone 60 years of age or older?

No - If no, please skip to Step 9. Yes - If yes, answer the following questions in Step 8.

Is this person(s) receiving disability benefits?

No Yes - If yes, from what source? _____

Is this person(s) unable to prepare meals due to a disability?

No Yes

If you answered "Yes" to all three questions in Step 8, does this person(s) want to receive SNAP separately from the other people you live with?

No Yes

Step 9: Tell us about the household's finances

Have you or the people in your household received, or expect to receive, income* this month?

No Yes - If yes, please complete the table below.

*Income refers to all the money that you and the people in your home receive. This includes earnings from employment or self-employment, child or spousal support, disability benefits, retirement benefits, Workers' Compensation, Unemployment Compensation, Social Security, SSI, Veterans' Benefits, Ohio Works First (OWF), gifts of money from individuals, etc.

Name	Type of Income or Name of Employer	How Often Received (weekly, bi-weekly, etc.)	Income Amount (before taxes)	Date Last Received

How much do you and the people in your household have in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

Give your best estimate of the total amount: \$ _____

Do you and the people in your household have more than one million total dollars in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

No Yes

Did anyone in your household leave a job or lose a job within the last 60 days?

No Yes - If yes, who? _____
 When? _____
 For what reason? _____

Is anyone in your household on strike from a job?

No Yes - If yes, who? _____

This Form Continues on the Next Page



Step 10: Tell us about the applicant's household expenses

Check all that apply. List the amount for each expense.

- Child/Dependent Care Costs:**
Estimated Amount Paid per Month: \$ _____
- Child or Spousal Support Payments Made to Someone Outside Your Household**
Estimated Amount Paid per Month: \$ _____
- Medical Expenses for Anyone Who is Disabled or Age 60 or Older.** These include expenses such as medical bills, prescriptions, health insurance premiums, transportation to medical appointments, or other medical services.
Estimated Amount Paid per Month: \$ _____
- Rent, Mortgage Payments, Lot Rent, Property Taxes, Homeowners' Insurance, etc.**
Estimated Amount Paid per Month: \$ _____

Do you pay for heat or air conditioning? Yes No

I pay for the following utilities (check all that apply):

- Telephone
 Trash
 Sewage
 Water
 Electric
 Gas

Step 11: If applying for Child Care Assistance, please tell us why the applicant needs child care

*If you or the people in your home are working, attending school, or participating in a training program, **please complete the table below with all qualifying activities.** If employed, please list your current employer. This includes self-employment and odd jobs. If you need more space, write your answers on an extra piece of paper and attach it to this form.*

Household Member 1 Name	Employer / School / Training Information Name
Activity Phone Number	Start Date / End Date
Address	
Household Member Work / School / Training Schedule	
<input type="checkbox"/> Sun From _____ to _____	<input type="checkbox"/> Thurs From _____ to _____
<input type="checkbox"/> Mon From _____ to _____	<input type="checkbox"/> Fri From _____ to _____
<input type="checkbox"/> Tues From _____ to _____	<input type="checkbox"/> Sat From _____ to _____
<input type="checkbox"/> Wed From _____ to _____	<input type="checkbox"/> Varies week to week _____
Household Member 2 Name	Employer / School / Training Information Name
Activity Phone Number	Start Date / End Date
Address	

Household Member Work / School / Training Schedule

<input type="checkbox"/> Sun From _____ to _____	<input type="checkbox"/> Thurs From _____ to _____
<input type="checkbox"/> Mon From _____ to _____	<input type="checkbox"/> Fri From _____ to _____
<input type="checkbox"/> Tues From _____ to _____	<input type="checkbox"/> Sat From _____ to _____
<input type="checkbox"/> Wed From _____ to _____	<input type="checkbox"/> Varies week to week _____

Household Member 3 Name	Employer / School / Training Information Name
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Activity Phone Number	Start Date / End Date
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Address

Household Work / School / Training Schedule

<input type="checkbox"/> Sun From _____ to _____	<input type="checkbox"/> Thurs From _____ to _____
<input type="checkbox"/> Mon From _____ to _____	<input type="checkbox"/> Fri From _____ to _____
<input type="checkbox"/> Tues From _____ to _____	<input type="checkbox"/> Sat From _____ to _____
<input type="checkbox"/> Wed From _____ to _____	<input type="checkbox"/> Varies week to week _____

Step 12: Tell us about the child(ren) who need(s) child care

Child 1 - Name (First, Middle, Last)	Child's Mother's Maiden Name	City of Birth
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Relationship to Applicant	Child's Preferred Spoken Language
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Is the child a U.S. Citizen or a Qualified Non-Citizen? **Note:** You must provide verification in order to receive Child Care Assistance.

Yes No - My child is **NOT** a U.S. Citizen or a Qualified Non-Citizen

Child's Needs: Does the child require Protective Child Care? Yes No - My child does **NOT** require Protective Child Care

If **YES**, is there a case plan? No - My child does **NOT** have a case plan

Is the child in Head Start?

Yes - What is their schedule? From _____ to _____ No - My child is **NOT** in Head Start

Days/Hours Child Care is Needed

<input type="checkbox"/> Sun From _____ to _____	<input type="checkbox"/> Wed From _____ to _____
<input type="checkbox"/> Mon From _____ to _____	<input type="checkbox"/> Thurs From _____ to _____
<input type="checkbox"/> Tues From _____ to _____	<input type="checkbox"/> F From _____ to _____
	<input type="checkbox"/> Sat From _____ to _____

Provider Name	Provider Address	City	State	Zip Code
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Child 2

Child 2 - Name (First, Middle, Last)		Child's Mother's Maiden Name	City of Birth	
Relationship to Applicant		Child's Preferred Spoken Language		
Is the child a U.S. Citizen or a Qualified Non-Citizen? Note: You must provide verification in order to receive Child Care Assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No - My child is NOT a U.S. Citizen or a Qualified Non-Citizen				
Child's Needs: Does the child require Protective Child Care? <input type="checkbox"/> Yes <input type="checkbox"/> No - My child does NOT require Protective Child Care If YES , is there a case plan? <input type="checkbox"/> Yes <input type="checkbox"/> No - My child does NOT have a case plan				
Is the child in Head Start? <input type="checkbox"/> Yes - What is their schedule? From _____ to _____ <input type="checkbox"/> No - My child is NOT in Head Start				
Days/Hours Child Care is needed				
<input type="checkbox"/> Sun From _____ to _____	<input type="checkbox"/> Mon From _____ to _____	<input type="checkbox"/> Tues From _____ to _____	<input type="checkbox"/> Wed From _____ to _____	<input type="checkbox"/> Thurs From _____ to _____
<input type="checkbox"/> Fri From _____ to _____	<input type="checkbox"/> Sat From _____ to _____			
Provider Name	Provider Address	City	State	Zip Code

Child 3

Child 3 - Name (First, Middle, Last)		Child's Mother's Maiden Name	City of Birth	
Relationship to Applicant		Child's Preferred Spoken Language		
Is the child a U.S. Citizen or a Qualified Non-Citizen? Note: You must provide verification in order to receive Child Care Assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No - My child is NOT a U.S. Citizen or a Qualified Non-Citizen				
Child's Needs: Does the child require Protective Child Care? <input type="checkbox"/> Yes <input type="checkbox"/> No - My child does NOT require Protective Child Care If YES , is there a case plan? <input type="checkbox"/> Yes <input type="checkbox"/> No - My child does NOT have a case plan				
Is the child in Head Start? <input type="checkbox"/> Yes - What is their schedule? From _____ to _____ <input type="checkbox"/> No - My child is NOT in Head Start				
Days/Hours Child Care is needed				
<input type="checkbox"/> Sun From _____ to _____	<input type="checkbox"/> Mon From _____ to _____	<input type="checkbox"/> Tues From _____ to _____	<input type="checkbox"/> Wed From _____ to _____	<input type="checkbox"/> Thurs From _____ to _____
<input type="checkbox"/> Fri From _____ to _____	<input type="checkbox"/> Sat From _____ to _____			
Provider Name	Provider Address	City	State	Zip Code

Child 4

Child 4 - Name (First, Middle, Last)		Child's Mother's Maiden Name	City of Birth	
Relationship to Applicant		Child's Preferred Spoken Language		
Is the child a U.S. Citizen or a Qualified Non-Citizen? Note: You must provide verification in order to receive Child Care Assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No - My child is NOT a U.S. Citizen or a Qualified Non-Citizen				
Child's Needs: Does the child require Protective Child Care? <input type="checkbox"/> Yes <input type="checkbox"/> No - My child does NOT require Protective Child Care If YES , is there a case plan? <input type="checkbox"/> Yes <input type="checkbox"/> No - My child does NOT have a case plan				
Is the child in Head Start? <input type="checkbox"/> Yes - What is their schedule? From _____ to _____ <input type="checkbox"/> No - My child is NOT in Head Start				
Days/Hours Child Care is needed <input type="checkbox"/> Sun From _____ to _____ <input type="checkbox"/> Wed From _____ to _____ <input type="checkbox"/> Mon From _____ to _____ <input type="checkbox"/> Thurs From _____ to _____ <input type="checkbox"/> Tues From _____ to _____ <input type="checkbox"/> Fri From _____ to _____ <input type="checkbox"/> Sat From _____ to _____				
Provider Name	Provider Address	City	State	Zip Code
Does your child(ren) have a chronic health condition, developmental disability, or special need? <input type="checkbox"/> No - My child does NOT have a chronic health condition, developmental disability, or special need <input type="checkbox"/> Yes - Please fill out the chart below:				
Name (First, Middle, Last)		Describe Child's Specific Needs		

This Form Continues on the Next Page



Step 13: Tell us about the school attendance of the child(ren) who need(s) care

Note: Complete this section if any child(ren) is attending or will be attending Kindergarten or higher grade school

Child's Name (First, Middle, Last)	Current Grade Level	School Name and Address	School Hours (ex: 8am - 3pm)	Kindergarten Schedule	School Year Start End Date
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Full Day	
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Full Day	
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Full Day	
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Full Day	

Step 14: Please review the following information carefully and sign on the last page

BY SIGNING THIS APPLICATION:

- ▶ **For all programs (SNAP, Cash, Child Care, and/or Medical Assistance), I acknowledge and agree:**
 - To the questions on this form and certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or immigration status of each household member applying for assistance.
 - The county Job and Family Services (JFS) office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of assistance and/or in some instances, I may be asked to give consent to the county JFS office to make those contacts.
 - I may be required to cooperate with the child support enforcement agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the CSEA, a referral will be submitted to the agency on my behalf. I also understand that if I am not required to cooperate with the CSEA, I may request child support services by completing the Application for Child Support Services (JFS Form 07076).
 - The county JFS office can assist me with getting required verifications as long as I cooperate.
 - The law provides a penalty of fine or imprisonment, or both, for anyone convicted of fraudulently receiving assistance for which he or she is not eligible.
 - My signature below gives the county JFS office permission to access available information in the Support Enforcement Tracking System (SETS) to verify my child/spousal/medical support income.
 - The status of non-citizen household members may be subject to verification by the United States Citizenship and Immigration Services (USCIS) through the submission of information from the application to USCIS through the Systematic Alien Verification and Eligibility (SAVE) System. The submitted information received from USCIS may affect the household's eligibility and level of benefits.
 - My signature below gives my consent and authorizes the county JFS office to access the Ohio Benefits Worker Portal for the purpose of verifying the citizenship status of the children in this case and for verification of the receipt of additional public assistance. I may revoke this authorization at any time by notifying the county JFS office in writing.
 - You have the right to request a county conference and a state hearing if you disagree with the action taken on your case. To request a county conference you should contact your county JFS office or review your notices received in the mail.

Step 14: Please review the following information and sign (Continued)

► **If I applied for SNAP benefits, I acknowledge and agree:**

- By signing this application, that information will be requested from the Income and Eligibility Verification System (IEVS) and information may be verified through whatever contacts are necessary to determine my eligibility.
 - Social Security Numbers (SSNs) will be used to check the identity of household members, prevent duplicate participation, and make changes to my case. If any household member does not provide their SSN, they will be designated as a non-applicant. This means they will NOT be considered as an applicant and will not be eligible for SNAP. Providing any requested information, including the SSN of each household member, is voluntary. However, failure to provide requested information to establish my eligibility for assistance will result in the denial or reduction of SNAP benefits to my household. Information collected on the application may be disclosed to law enforcement officials for the purpose of apprehending individuals fleeing to avoid the law.
 - If a court of law finds me guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, I will not be eligible for benefits for two years for the first offense, and permanently for the second offense.
 - If a court of law finds me guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
 - SNAP benefits are issued on the Ohio Direction Card and I am prohibited from using my SNAP benefits to purchase or sell firearms or controlled substances. I understand that I can use SNAP benefits to only buy eligible items. I cannot use SNAP benefits to buy non-food items such as alcoholic drinks, tobacco, etc.
 - Any member of my household who intentionally breaks the rules may not get SNAP for one year for the first offense, two years for the second offense, and permanently for the third offense.
 - If a court of law finds me guilty of having trafficked benefits for a total amount of \$500 or more, I will be permanently ineligible to participate in SNAP upon the first offense of such violation.
 - I am prohibited from selling, trading or purchasing SNAP benefits and cannot use someone else's SNAP benefits for my household. I can be disqualified from the SNAP program for any of these violations.
 - I cannot use benefits to buy food for someone who is not a member of my household.
 - If I am found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, I will be ineligible to participate in the SNAP for a period of 10 years.
 - The information provided with my application for SNAP benefits will be subject to verification by Federal, State and local officials to determine if the information is factual and if any information is incorrect, my SNAP benefits may be denied. I may be subject to criminal prosecution for knowingly providing incorrect information.
 - If I receive SNAP benefits that I should not have gotten:
 - I may be ordered to repay the benefits
 - I may be charged with fraud
 - I may be fined (up to \$250,000) or sent to prison (up to 20 years) or both
 - I may be prohibited from receiving benefits in the future.
 - I will be held liable for any SNAP benefits that I receive that I should not have gotten if my authorized representative gives incorrect information.
 - If I do not agree with an action taken on my case, I can file for a county conference or a state hearing. I can ask for a county conference or state hearing online, by email or mail, or by contacting my county JFS office. I can ask someone to attend the hearing in my place with my signed authorization.
 - If my case is chosen at random to make sure that I am eligible for the assistance I receive and that I am receiving the correct amount, I must cooperate if my case is reviewed. If I refuse to cooperate with a review, my benefits may be terminated.
 - Within 60 days of applying and at any time while receiving benefits, an employed or self-employed person is not to voluntarily and without good cause, quit the job or reduce work hours to less than 30 hours per week or to earning less than the federal minimum wage x 30 hours to remain eligible to participate in SNAP.
- **If I applied for Cash Assistance benefits, I acknowledge and agree:**
- By signing this application and receiving OWF Cash Assistance, I may be required to cooperate with the local Child Support Enforcement Agency (CSEA) in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the local Child Support Enforcement Agency (CSEA), a referral will be submitted to the agency on my behalf and any rights to all support

Step 14: Please review the following information and sign (Continued)

owed to me and the minor children in the assistance group will be assigned to the State of Ohio.

- By signing this application and receiving OWF Cash Assistance, I am assigning to the State of Ohio any rights to child or spousal support that is owed to me and/or the minor children in the assistance group during the Ohio Works First eligibility period.
- Cash benefits are issued on the EPPICard™. The EPPICard™ can be used at MasterCard member banks, ATMs and most retailers that accept MasterCard. I cannot use my EPPICard at liquor stores, casinos, gaming establishments, or any retail establishments that provide adult entertainment in which performers disrobe or perform in an unclothed state for entertainment purposes.
- I must activate my EPPICard™ within 90 days from when benefits and my first card is issued and that if my EPPICard™ is not activated within 90 days, my benefits will be removed from my account.
- ▶ **If I applied for Child Care benefits, I acknowledge and agree:**
 - My county JFS office or ODJFS may share approval, denial, and submission status of my child care application to the provider(s) listed on this application or to any provider named as a result of a change to my application. I understand that the sharing of this information to any provider not listed on this application shall require the signing of a separate release per Ohio Revised Code.
 - I will be able to use Publicly Funded Child Care (PFCC) benefits only for children who are eligible and only up to the maximum hours authorized by the county JFS office. To remain eligible for PFCC benefits, the required copayment (if applicable) must be paid by me to the provider. Failure to pay the required copayment may result in termination of PFCC benefits.
 - If I am approved for child care assistance, I will be responsible for accurately recording my child's attendance at the child care program by utilizing an automated attendance tracking system. This includes registering in the system and creating personal identification information that I will use to access the system and to serve as my electronic signature. I understand that my child care provider is not permitted to record my child's attendance on my behalf and may not have access to my personal identification information. I understand that the attendance tracking system may take my photo or a photo of my designee/sponsor as part of the login and logout process. I understand that I am responsible for approving any changes that my provider makes in the attendance tracking system regarding my child's attendance at the program.
 - If my child attends a Step Up To Quality rated program, and if an assessment is completed on my child, the data will be collected and reported to ODJFS.
 - I have received an explanation regarding the requirements for determining child care eligibility, the reasons why I may not be eligible, my right to a state hearing, and my responsibility for reporting changes to the county JFS office and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification of information or misuse of child care benefits, including misuse of the automated child care attendance tracking system.
 - I must report any changes which affect my eligibility to the county JFS office, including changes in family income, hours of employment/training/education, family size, and address. I understand that I must report changes within 10 days of the date they occur.
 - My signature also gives consent to issue a system generated statewide student identifier (SSID) for each child listed on this application.
 - Information About Child Care Providers:
 - Parents may select any program approved to offer publicly funded child care. These programs include centers, family child care homes, in-home aides and child day camps located throughout the state of Ohio.
 - If you would like assistance with selecting a provider, you may contact your local Child Care Resource and Referral Agency.
 - You may use our Child Care Directory to look for programs that fit your child care needs at <https://childcaresearch.ohio.gov>. The directory allows you to search by location, type of program, services offered and days and hours of operation. Information is provided about each program including Step Up To Quality rating, any additional accreditation or affiliation, licensing inspections and substantiated complaints.
 - Step Up To Quality helps families choose child care programs that go beyond the minimum standards of licensing. Rated programs demonstrate higher levels of quality in a variety of ways. If you would like more information about the Step Up To Quality program, visit the DCY child care website at <https://jfs.ohio.gov/child-care/step-up-to-quality/for-families>.
 - You may also visit our website to learn more about Medicaid health screenings and early intervention services for your child. For this information, go to <https://jfs.ohio.gov/child-care/resources/02-special-needs-child-care>.
 - If you would like to make a complaint about a Provider regarding suspected violations of licensing rules, you may contact the Child Care Policy Help Desk at 1-877-302-2347, option 4.

► **If I applied for Medical Assistance benefits, I acknowledge and agree:**

- Under penalty of perjury, I have disclosed all annuities and other similar financial devices in which I and/or my spouse have any interest.
- By signing this application and receiving Medicaid, I am assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to me and/or to the minor child(ren) in my assistance group. I understand that I must tell the Ohio Department of Medicaid about any health insurance I have or about any third party responsible for my medical expenses. I give the Department the right to pursue medical support from an ex-spouse or parent. If I think that cooperating to collect medical support will harm my child(ren) or myself, I understand that I can tell the Department and I may not have to cooperate.
- That the Ohio Department of Medicaid will check my answers using Social Security numbers and information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security (DHS), and others. If the information does not match, the Ohio Department of Medicaid may ask me to send more information.
- The Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
 - My application for medical assistance is denied; or
 - My eligibility for medical assistance ends; or
 - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization, I understand that my medical assistance may be denied or discontinued.
- If I am permanently institutionalized or age 55 or older when I receive Medicaid benefits, after my death the Estate Recovery Program may recover payments for the cost of my care paid by Medicaid from my estate. The cost of my care may include the capitation payment that Medicaid pays to my managed care plan, even if the capitation payment is greater than the cost of the services I actually received.
- I authorize any person who furnishes health care, medical supplies, or services to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. I understand that I authorize the previously mentioned departments to exchange any information I have provided to enable the departments to determine my eligibility for medical assistance benefits.
- The Medicaid Program requires enrollment for most recipients into a Managed Care Plan. You will receive information in the mail about this if you are determined eligible for Medicaid.
- The Healthchek program offers preventative healthcare services to all Medicaid eligible children under age 21 and pregnant women. A Medicaid eligible child may receive free Healthchek screenings for vision and hearing.

I authorize _____ to be my representative for _____ program.
(Name of Auth Rep) (Ex. SNAP, OWF)

i. For Medicaid: You may be asked to provide further documentation of the authorization in order to comply with OAC 5160-1-33.

- If you need more than one authorized representative, please contact your county JFS office.

Signature of Applicant OR Authorized Representative	Date
Print Name of Applicant OR Authorized Representative	Date

- END OF APPLICATION -

Turn this application in to your local County JFS Office

Please refer to the insert for the address for your local County Department of Job and Family Services.

Please Return to:
Muskingum Valley Preschool
1605 Airport Rd
New Lexington, OH 43764
P: 740-343-0680 F: 740-343-0683
Email: enrollment@mvesc.org

EMERGENCY MEDICAL RELEASE FORM

Child's Full Name _____ Birth Date _____
Address _____ County _____

Guardian's Name _____	Guardian's Name _____
Relationship to Child _____	Relationship to Child _____
Place of Employment _____	Place of Employment _____
Work # _____	Work # _____
Cell# _____	Cell# _____
Email Address _____	Email Address _____

Please Complete Medical/Dental Provider:

Physician _____	Dentist _____
Address _____	Address _____
Phone # _____	Phone # _____

PART I: TO GRANT CONSENT

Facts concerning the child's medical history, including allergies, medications being taken, and physical impairments to which a physician should be alerted: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

I give Muskingum Valley Preschool my permission to transport my child _____
name of child
to _____ for emergency medical care or to _____
hospital/clinic dentist
for emergency dental care or to nearest available source of assistance.

Parent/Guardian Signature _____ Date _____

****DO NOT COMPLETE PART II IF YOU COMPLETED PART I****

PART II: REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Parent/Guardian Signature _____ Date _____

Please list **3 people** that can be contacted at **3 different addresses & phone numbers** in the event that reasonable attempts to contact parent/guardian have been unsuccessful. **It is a state requirement to have three (3) sets of contact information on file for all children. **

1. Name _____
Address _____ Phone _____
Relationship to Child _____

2. Name _____
Address _____ Phone _____
Relationship to Child _____

3. Name _____
Address _____ Phone _____
Relationship to Child _____

Please list **all** other persons who have permission to pick up your child. Persons already listed above do not need to be listed again. Anyone picking or dropping off your child must be 18 years of age and photo identification is required. Anyone not listed will not be permitted to pick up your child without prior permission. Please feel free to contact us at any time to change and/or update this listing.

Name _____ Phone _____
Relationship to Child _____

TRANSPORTATION

____ I grant permission for my child to be transported by my local public school to and from school daily.

____ I grant permission for my child to be transported by my local public school as needed throughout the school year for field trips and special activities.

____ I will be responsible for transporting my child to and from school.

I have completed and agree with the information on this form.

Parent/Guardian Signature _____ Date _____

Please Return to:
Muskingum Valley Preschool
1605 Airport Rd
New Lexington, OH 43764
P: 740-343-0680 F: 740-343-0683
Email: enrollment@mvesc.org

Permission Form

Please READ and then SIGN

Child's Name _____ Date _____
Parent/Guardian Name _____

Photograph/Video/Electronic/Social Media Permission

Our preschool program occasionally takes photographs and videos of children participating in classroom activities, special events, and learning experiences. These images may be used to celebrate learning, document activities, and share information about our program.

Common uses of preschool images:

- Classroom documentation (bulletin boards, portfolios, learning displays)
- Classroom communication platforms used to share updates, photos, or videos securely with enrolled families (e.g., program-approved apps or digital communication tools)
- Program publications (newsletters, flyers, brochures, reports)
- Program website and/or social media pages (e.g., Facebook)
- Local media or community publications (newspaper, district publications)

Important Notes

- Your **child's name will not be included** with photos or videos shared publicly.
- Images will be used respectfully and only for educational or program-related purposes.
- Permission may be **withdrawn at any time** by submitting a written request.

_____ Yes, I give permission for my child's image to be used.

_____ No, my child's photo and personally identifiable information **CANNOT** be used.

Parent/Guardian Signature

Field Trip Permission

Visits to places of educational interest are planned during each school year. Teachers and assistants always accompany the students and, if transportation is needed, school buses will be provided. Field trips are always announced in advance. Individual permission will be requested at that time.

The teacher in charge will provide supervision and care which will help to ensure safety for each child. Parents are encouraged to come along.

_____ Yes, my child may go on planned field trips.

_____ No, I do not want my child to go on planned field trips. I will keep my child home those days.

Parent /Guardian Signature

Screening and Assessment Consent

The Ohio Department of Children and Youth (DCY) requires our preschool program to conduct developmental screenings and assessments throughout the school year. We use the Early Learning Assessment (ELA) to monitor children's progress, and information is shared with DCY two times per year. Progress will also be shared with parents through reports in the fall, winter, and spring.

For children receiving special education services, we are also mandated to report progress and outcomes using the Child Outcome Summary.

Assessment results may also be shared with your local school district on a need-to-know basis.

_____ Yes, I give my permission to screen and assess my child's progress and share the results with the Ohio Department of Education and your local school district.

_____ No, I do not give my permission to screen or assess my child's progress.

Parent/Guardian Signature

Roster Permission

Our preschool program is required by Ohio law to maintain a basic classroom roster for each group of children. This roster includes:

- child's name
- parent/guardian name
- phone number

This roster is only shared with parents of children in the same classroom and is available upon request. Please check "yes" or "no" and sign below.

_____ Yes, I give my permission for my child's information to be on the class roster.

_____ No, I do not give permission for my child's information to be on the class roster.

Parent/Guardian Signature

Release of Information Permission

I give permission for my child's educational records (such as evaluations, service plans, and progress information) to be shared with other agencies involved in supporting my child's education and development. This information will be shared only to help agencies work together to best meet my child's needs. Agencies that may receive information include, but are not limited to: Head Start, Local Health Department, Family Services Organizations (Jobs and Family Services, Board of DD, Therapy providers, etc.), and your local school district.

I understand that this information will be kept confidential and shared only with my permission. I may withdraw this permission at any time by providing written notice.

_____ Yes, I give my permission to share my child's records with other involved agencies.

_____ No, I do not give my permission to share my child's records with other involved agencies.

Parent/Guardian Signature

Please Return to:
 Muskingum Valley Preschool
 1605 Airport Rd
 New Lexington, OH 43764
 P: 740-343-0680 F: 740-343-0683
 Email: enrollment@mvesc.org

CHILD MEDICAL STATEMENT

Child's Name (print or type)	Date of Birth
Parent's Name	School Site Attending

Height _____ Weight _____ Blood Pressure _____

Lead* _____ Date* _____ Hemoglobin* _____ Date* _____

(*) Include previous results from file if not indicated for completion at this visit.

Vision Screening: Right 20/ _____ Left 20/ _____ Hearing Screening: Pass _____ Fail _____

This child has the immunizations for admission to school or is exempt from state requirements for medical reasons. Required Immunizations (enter month, day and year):

Immunizations	Please Circle One	
Complete for Age	Yes	No
In Progress	Yes	No

***Please attach current immunization record available**

Exempt from Immunizations	Please Circle One	
Religious Conviction	Yes	No
Health Concern	Yes	No
Other:		

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Well Nourished			Well Developed		
Skin			Head		
Eyes			Ears		
Nose/Mouth			Teeth		
Lungs			Heart		
Abdomen			Genitalia		
Bones, Joints, Muscles			Neurology		
Comments:	List any handicaps, allergies or health conditions:				
Next Appt: mo/yr					

Based upon his/her medical history and physical condition at the time of this examination, this child appears to be free from apparent communicable disease and in suitable condition to receive child day care.

Name of Physician (please print)	Telephone Number
Address	
Physician's Signature	Date

Please Return to:
 Muskingum Valley Preschool
 1605 Airport Rd
 New Lexington, OH 43764
 P: 740-343-0680 F: 740-343-0683
 Email: enrollment@mvesc.org

DENTAL EXAM FORM

Child's Name (print or type)	Date of Birth
Parent's Name	School Site Attending

Is the child now receiving any of the following?

(If yes, include length of time receiving fluoride)
 Topical fluoride application: ___ No ___ Unknown ___ Yes _____
 Fluoridated water: ___ No ___ Unknown ___ Yes _____
 Fluoride supplement diet: ___ No ___ Unknown ___ Yes _____

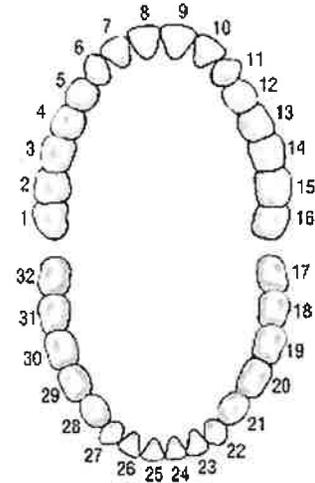
_____ Tablets _____ Liquid
 Does the child have any trouble with teeth, gums or mouth? ___ Yes ___ No
 If so, what kind? _____

Has the child previously seen a dentist? ___ Yes ___ No
 Dentist Name _____ Date of last visit _____
 Is child under physician's care? ___ Yes ___ No
 Physician Name _____
 Is child receiving medication? ___ Yes ___ No

Services provided this visit:

Tooth Number	Description of work
_____	_____
_____	_____
_____	_____

Comments: _____



Is follow-up required? ___ Yes ___ No **** (If yes, see section below)**

Name Of Dentist	Telephone Number
Address	
Dentist Signature	Date Signed

****PLEASE COMPLETE THIS SECTION FOR FOLLOW-UP REQUIREMENTS: ****

Please provide a written summary of the following services required:

- * For the relief of pain or infection
- * Restoration and/or pulp therapy of decayed permanent teeth
- * Extraction prophylaxis & instructions in self-care oral hygiene procedures

Recommended follow-up dental needs (check all that apply):

- () A. Treatment (restoration, pulp therapy, extraction) () B. Cleaning
 () C. Fluoride () D. Other (please specify below)

Explain Recommended Services:

Approximate number of visits needed to be complete care _____

Has a follow-up appointment been scheduled? Yes ___ No ___ **Date:** _____

