



Required Registration Documents

Northern Local

Enrollment Packet

- ☐ MVESC Preschool Enrollment Application - www.mvesc.org
- ☐ JFS Child Care Assistance Application (Form 7200)
- ☐ Emergency Medical Authorization Form
- ☐ Permission and Information Release Form

Additional Required Documents

- ☐ Child's birth certificate (birth or hospital records are not accepted)
- ☐ Child's current Immunization Record, must include child's name and date of birth
- ☐ Proof of residency (e.g., utility bill, rental receipt, lease agreement, tax statement, or building permit)
- ☐ Proof of income (e.g., most recent 30 days of pay stubs, Form 1040, W-2, SSI, or OWF documentation)
- ☐ Custody papers, if applicable

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

Please return completed documents to:

Muskingum Valley ESC – Preschool
205 N. 7th St.

Zanesville, OH 43701

P: 740-452-4518

F: 740-455-6702

Email: mvpreschool@mvesc.org

Subject: Preschool Application – Child's Name

Office Use:

Child's Name: _____ Site: _____ Date: _____

Please Return to:
Muskingum Valley ESC - Preschool
205 N. 7th Street
Zanesville, OH 43701
P: 740-452-4518 F: 740-455-6702
E: mvpreschool@mvesc.org



NORTHERN LOCAL PRESCHOOL ENROLLMENT FORM

SELECT ONE:

☐ Somerset ☐ Sheridan MS (Glenford) ☐ Thornville

PREFERRED DAYS:

☐ M/T ☐ Th/F

(all classes are 2 full days per week)

Student Information

Child's Full Name

First _____ Middle _____ Last _____ Nickname/Preferred Name _____

Birthdate: ____ / ____ / ____ Birth City: _____ Birth State: _____

Sex: ☐ Male ☐ Female Primary Language Spoken in the home: _____

Address: _____
Street or PO Box _____ City _____ Zip _____

County: _____ School District of Residence: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Two or More Races ☐ Unknown/Not Reported

Who does the child primarily live with?

☐ Mother and Father ☐ Mother ☐ Father ☐ Parent and Stepparent ☐ Legal Guardian
☐ Other: _____

Does the child have a custody or guardianship arrangement that affects enrollment or who may make educational decisions? ☐ No ☐ Yes — documentation attached

Parent/Guardian Information

Mother

Full Name: _____ DOB: _____

Relationship to Child: _____ Maiden Name: _____

Phone: _____ Email: _____

Father

Full Name: _____ DOB: _____

Relationship to Child: _____

Phone: _____ Email: _____

Legal Guardian Information

Complete this section if the child does not live with a parent or if someone other than a parent has legal custody or guardianship.

Legal Guardian: _____

Relationship to Child: _____

Phone: _____ Email: _____

Household Information

This information is used to determine tuition.

Other Household Members

Please list other children and adults living in the child's household who are not listed above.

Name	Date of Birth	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

Household Income

Is anyone in the household currently receiving income? ☐ No ☐ Yes Household Income: _____

Please provide income documentation as described in Required Documentation.

Developmental and Educational Information

The following information helps us understand your child's current development and identify whether additional screening, evaluation, or support may be helpful. If your child has an IEP or receives special education or related services, this information will help our preschool team coordinate services and support your child's needs.

Is your child fully toilet-trained? ☐ Yes ☐ No

Muskingum Valley ESC Preschool requires children to be fully toilet-trained in order to enroll in the preschool program.

Do you or your child's doctor have concerns about your child's ability to:

☐ Speak understandably ☐ Use complete sentences ☐ Answer simple questions

☐ Hold or use a pencil or crayon ☐ Walk up or down stairs ☐ Run

☐ Other: _____

If you checked any concerns above, please explain: _____

Does your child have a diagnosed disability or current IEP? ☐ Yes ☐ No

If yes, please describe the disability or area of need, if known: _____

Has your child ever received or does your child currently receive services for a disability or developmental concern? ☐ Yes ☐ No

If yes, please list the service(s), provider, or school/program, if known: _____

Have there been any significant changes in your child's life that you would like us to know about? This information is used only to help us better understand and support your child and family. If yes, please share anything you would like us to know:

Applications are reviewed according to MVESC Preschool's selection criteria for enrollment. You will be notified if your child has been: offered preschool placement, placed on the waiting list, or if further information is needed before the application can be processed.

Submitting an application does not guarantee enrollment or placement in a particular classroom or session.

To the best of my knowledge, all the information provided on the application is true and accurate. I understand that additional documentation may be requested. Incorrect information could lead to the dismissal of my child from the program. I understand participation in the program is voluntary.

Parent/Guardian Signature

Date

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
A proud member of the
OhioMeansJobs network

SNAP, CASH, MEDICAL, AND/OR ECE 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.

Step 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**

☐ **Cash Assistance-** For families with a minor child(ren) or women who are pregnant

☐ **Refugee Cash Assistance (RCA)-** For refugees within 4 months of arrival

☐ **Medical Assistance**

☐ **OPP-** Preschool for ages 3 to kindergarten eligible

☐ **PFCC/CCVP-** Child Care for families working, in school/training

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

Do you need any of the following services?

☐ Large Print Notices

☐ Sign Language Interpreter

☐ Translator

☐ Other _____

What is your preferred language?

Spoken: _____

Written: _____

Have you, or anyone living with you, ever received SNAP, Cash, Medical, or ECE 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 ☐ 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. The applicant 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 qualified non-citizen 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 applying for SNAP, Cash, Medical, or ECE 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 (spouse, friend, etc.)	SSN (See instructions above)	Date of Birth	Sex	U.S. Citizen	Hispanic or Latino	Race
	Self			☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	
				☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ 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 or anyone in household pay for heat or air conditioning?

☐

Yes

☐

No

(check all that apply):

☐ Telephone

☐ Trash

☐ Sewage

☐ Water

☐ Electric

☐ Gas

Step 11: If applying for Early Care and Education assistance, please tell us why the applicant needs Early Care and Education assistance

If you or the people in your home are working, attending school, participating in a training program (e.g. CDL, STNA, Barber or Cosmetology) or are participating in a Substance Use Disorder program (inpatient, outpatient, AA/NA or counseling for substance use), **please complete the table below with all qualifying activities. 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- Include travel time needed

☐ Sun From _____ to _____	☐ Thurs From _____ to _____
☐ Mon From _____ to _____	☐ Fri From _____ to _____
☐ Tues From _____ to _____	☐ Sat From _____ to _____
☐ Wed From _____ to _____	☐ Varies week to week ☐ Yes ☐ No

Household Member 2 Name

Employer / School / Training Information Name

Activity Phone Number

Start Date / End Date

Address

Household Member Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____	☐ Thurs From _____ to _____
☐ Mon From _____ to _____	☐ Fri From _____ to _____
☐ Tues From _____ to _____	☐ Sat From _____ to _____
☐ Wed From _____ to _____	☐ Varies week to week ☐ Yes ☐ No

Household Member 3 Name

Employer / School / Training Information Name

Activity Phone Number

Start Date / End Date

Address

Household Work / School / Training Schedule- Include travel time needed

☐ Sun From _____ to _____	☐ Thurs From _____ to _____
☐ Mon From _____ to _____	☐ Fri From _____ to _____
☐ Tues From _____ to _____	☐ Sat From _____ to _____
☐ Wed From _____ to _____	☐ Varies week to week ☐ Yes ☐ No

Step 12: Tell us about the child(ren) who need(s) Early Care and Education

Child 1 - 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 ECE 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?If **YES**, is there a case plan?☐ Yes☐ No - My child does **NOT** require Protective Child Care☐ Yes ☐ 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**Is the child in kindergarten?**If **YES**, is the child AM or PM or Full-day?

Yes

No

☐ AM☐ PM☐ Full-day

Program Name

Program Address

City

State

Zip Code

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 ECE 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? ☐ Yes ☐ 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					
Is the child in kindergarten? If YES , is the child AM or PM or Full-day? Yes No ☐ AM ☐ PM ☐ Full-day					
Program Name		Program 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 ECE 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? ☐ Yes ☐ 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					
Is the child in kindergarten? If YES , is the child AM or PM or Full-day? Yes No ☐ AM ☐ PM ☐ Full-day					
Program Name		Program 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 ECE 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?

☐

Yes

☐

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

Is the child in kindergarten?

If **YES**, is the child AM or PM or Full-day?

Yes

No

☐

AM

☐

PM

☐

Full-day

Program Name

Program Address

City

State

Zip Code

Does your child(ren) who needs care have a chronic health condition, developmental disability, or special need?

☐

No - My child does **NOT** have a chronic health condition, developmental disability, or special need

☐

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
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ Full Day	
				☐ AM ☐ PM ☐ 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, ECE, 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 owed to me and the minor children in the assistance group will be assigned to the State of Ohio.

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

- 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 Early Care and Education (ECE), I acknowledge and agree:**
 - My county JFS office or DCY may share approval, denial, and submission status of my application to the program(s) listed on this application or to any program named as a result of a change to my application.
 - I understand that the sharing of this information to any program not listed on this application shall require the signing of a separate release per Ohio Revised Code.
 - I will be able to use ECE 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 program. Failure to pay the required copayment may result in termination of PFCC benefits.
 - If I am approved for services, I will be responsible for accurately recording my child's attendance at the 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 program 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 program 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 DCY.
 - I have received an explanation regarding the requirements for determining 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 benefits, including misuse of the automated child care attendance tracking system.
 - I must report any changes which affect my PFCC eligibility to the county JFS office, including changes in my income goes above 300% of the federal poverty level, long-term changes in participation in my qualifying activity and address changes. 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 ECE Programs:
 - Parents may select any program approved to offer ECE. These programs include centers, family child care homes, preschools, school-age care, in-home aides and child day camps located throughout the state of Ohio.
 - If you would like assistance with selecting a program, 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 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 website at <https://childrenandyouth.ohio.gov/for-providers/step-up-to-quality>.
 - 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 Healthchek | Medicaid and <https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/healthchek> and for Early Intervention services go to <https://ohioearlyintervention.org/>.
 - If you would like to make a complaint about a suspected violation of licensing rules, misuse, or fraud you may contact the Family and Customer Support Center at 1-844-234-5437.

► **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 Ohio Department of Medicaid 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 Ohio Department of Medicaid 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 for the Ohio Department of Medicaid to get information about me from financial institutions, 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 the age 21 and pregnant woman. 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)

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.

Ohio Department of Children and Youth

Emergency Medical Authorization for School-Based Preschool Programs

This form meets the requirement for Ohio Revised Code Section 3313.712. Programs may use this form or build their own.

Program Name _____

Student Name _____ Phone _____

Address _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Childcare Provider _____

Relationship _____ Daytime Phone _____

Address _____

Emergency Contact¹ #1 _____ Daytime Phone _____

Address _____

Emergency Contact #2 _____ Daytime Phone _____

Address _____

Emergency Contact #3 _____ Daytime Phone _____

Address _____

¹ Emergency contact information is required in accordance with Ohio Administrative Code Rule 5180:2-20-08
(Rev. 7/2026)

**PART I OR II MUST BE COMPLETED:**

PART I - TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

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 doctor, 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.

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

Signature of Parent/Guardian _____ Date _____

Address _____

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 (written instructions must be completed):

Signature of Parent/Guardian _____ Date _____

Address _____

**MUSKINGUM VALLEY PRESCHOOL
PERMISSION AND INFORMATION RELEASE FORM**

Please **READ** and then **SIGN**

CHILD'S NAME _____

DATE _____

PARENT/GUARDIAN NAME _____

SITE _____

PHOTOGRAPH / VIDEO / ELECTRONIC / SOCIAL MEDIA PERMISSION

Our preschool program may photograph or record children during classroom activities, special events, and learning experiences. Images may be used to document learning and communicate or 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 and other personally identifiable information **will not** be included when images are 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. Withdrawal applies to future use.

_____ **YES.** I give permission for my child's photograph/video image to be used.

_____ **NO.** I do not give permission for my child's photo/video image to be used as described above.

Parent/Guardian Signature _____ Date _____

HOLIDAY / CELEBRATION ACTIVITIES PERMISSION

Our preschool classrooms respect and reflect the diverse cultures, families, and beliefs of our children. Holiday and seasonal activities will be developmentally appropriate, connected to learning goals, and offered as optional choices.

Activities may include holiday-themed books, art, music, or classroom activities. Families will be given the opportunity to provide permission for activities that are outside the routine classroom experience.

_____ **YES.** My child may participate in optional holiday/seasonal activities.

_____ **NO.** My child may not participate in optional holiday/seasonal activities.

If NO, please list any specific concerns or activities you would like us to avoid:

Parent/Guardian Signature _____ Date _____



SCREENING AND ASSESSMENT CONSENT

Ohio Department of Children and Youth (DCY) requires preschool programs to screen and assess children's development and progress. Muskingum Valley Preschool may use tools such as the **Brigance, Ages & Stages Social-Emotional (ASQ)**, and **Early Learning Assessment (ELA)** to help monitor children's development and plan instruction.

Assessment information may be shared with families and, as appropriate, the local school district. ELA results are reported to DCY as required. For children receiving special education services, Child Outcome Summary (COS) information is also reported as required.

_____ I understand and acknowledge the preschool screening and assessment requirements described above.

Parent/Guardian Signature: _____ Date: _____

RELEASE OF INFORMATION PERMISSION

Muskingum Valley Preschool may share information from your child's preschool records with the local school district and other agencies involved in supporting your child, as appropriate. This may include enrollment, health, developmental, educational, and progress information (Kindergarten Transition).

Information will be shared only as needed to support your child, coordinate services, or meet program and legal requirements. Records will be kept confidential and are not shared with the general public.

_____ **YES.** I give permission for my child's preschool records to be shared with involved agencies as described above.

_____ **NO.** I do not give permission for my child's records to be shared with outside agencies, except when sharing is required or permitted by law.

Parent/Guardian Signature: _____ Date: _____

CLASSROOM ROSTER PERMISSION

Our preschool program maintains a classroom roster to help families connect with other families in their child's classroom. The roster may include your child's name, parent/guardian name, and phone number. It is shared only with families in the same classroom and is not made available to the general public.

_____ **YES.** I give permission for my child's information to be included on the classroom roster.

_____ **NO.** I do not give permission for my child's information to be included on the classroom roster.

Parent/Guardian Signature: _____ Date: _____