Dear Parent,

The Colorado Preschool Program was established by the Colorado General Assembly to provide tuition funds for families in need. All fees associated with District 20 preschools are covered for those who qualify. Qualifying criteria include, but are not limited to:

- Significant financial hardship
- Frequent relocations by the family
- Parental mental health issues
- Traumatic events in the child’s life
- Overseas deployment
- Language and social skill concerns
- Premature birth (prior to 32 weeks)

Eligibility requirements vary depending on age. Families of three-year-old applicants must qualify in multiple areas. Students must turn 3 or 4 years of age by October 1, 2015 to be eligible for the program.

The availability of preschool slots supported by CPP is subject to the Colorado legislative budget process, which determines the number of students who can receive funds each year. Final notification of funding for qualifying families will occur in May.

Completed application packets (including CPP application, and the Ages and Stages Questionnaire) should be submitted to the following:

D20 Preschool Office
Education and Administration Center
1110 Chapel Hills Drive
Colorado Springs, Colorado 80920
Phone (719) 234-1750

Sincerely,

Linda Hayes
Assistant Director for Special Education

District 20 does not discriminate on the basis of race, religion, national origin, sex, sexual orientation, or disability.
Colorado Preschool Program Application

Academy School District 20 is the recipient of a grant from Colorado Preschool Program which allows D20 to provide tuition free preschool to a limited number of 4 year old children who meet the eligibility criteria. Children must be considered vulnerable to starting grade school unprepared. If you believe your child may qualify, please fill out the following application.

Date: ______________________

Child’s Name: ________________________________________________________________

(As it appears on the birth certificate)

Child’s Date of Birth: _______________________ Gender _____ Age _____ Ethnicity: ____________

Parent(s) Names: ____________________________________________________________

Address: __________________________________________ Zip ______________

Phone: Home ___________ Cell _______________ Work ________________

Email address: ________________________________________________________________

D20 Neighborhood School ____________________________________________________

Primary Language Spoken in the Home: ________________________

Other Languages Spoken in the Home: ________________________

Please list all household members, including family members who were part of the household but are now deceased:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relationship to child</th>
<th>Date of Birth</th>
<th>Last Grade Completed</th>
<th>Deceased?</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Are any of your children adopted? □ No □ Yes - If yes, at what age? ________________________________

Child’s Strengths: ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Current Concerns: ________________________________________________________________

______________________________________________________________________________

Previous Preschool Experience: Where: ___________________________ Dates Attended: __________

Family Factors

Other family factors that are currently affecting your family (unemployment, financial instability, health, disability, addiction, unsafe living conditions)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Why do you want your child to attend preschool?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Would your child be able to attend Preschool without the CPP Program?  Yes ☐  No ☐

In addition to this form you will need to fill out an Ages and Stages Questionnaire (ASQ). The ASQ will be available at the D20 Preschool Office. You may pick up a form from the office or call to have one mailed or emailed to you at 719-234-1750.
Health History

Child’s Name: _______________________________  Date Form Completed: ____________________

Current Health Status

How is your child’s health now? □ Excellent  □ Good  □ Fair  □ Poor

Explain any health problems or concerns: ______________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Has your child ever seen a medical specialist?  □ No  □ Yes

Explain: _______________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Does your child have a known medical diagnosis?  □ No  □ Yes

If yes, what is the diagnosis: _______________________________________________________________
At what age was your child diagnosed? __________________________

Is your child on medication now? □ No  □ Yes  Medication Name: ___________________________
When: _______________ Dosage: ___________________________

Date of last physical: _______________ Primary Physician: _______________________________________

Physician Address: __________________________________________________________

Hospital of choice: ___________________________

Are your child’s shots up to date? □ Yes  □ No - Reason: __________________________

Date of last vision test: _______________ Where? _______________________ Results: ________________

Does your child wear glasses or contact lenses? □ No  □ Yes

Explain vision/eye problem(s) and when it started: _______________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Did your baby pass his/her Newborn Hearing Screening? □ Yes  □ No

Date of last hearing test: _______________ Where? _______________________ Results: ________________

Do you think your child may having a hearing problem? □ No  □ Yes

If yes, explain: __________________________________________________________

Date of visit to dentist: _______________ Dentist’s Name: _____________________________
Dentist’s Address: __________________________________________________________

Medical History

Has your child had any of the following?  Please check and comment on the lines below.

<table>
<thead>
<tr>
<th>Upper respiratory infections</th>
<th>High fever</th>
<th>Sleeping problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Convulsions/seizure</td>
<td>Dental problems</td>
</tr>
<tr>
<td>Frequent ear infections</td>
<td>Asthma</td>
<td>Feeding/eating problems</td>
</tr>
<tr>
<td>Frequent sore throat</td>
<td>Heart problem/condition</td>
<td>Weight problems</td>
</tr>
<tr>
<td>Stomach aches</td>
<td>Social emotional problems</td>
<td>Hyperactive</td>
</tr>
<tr>
<td>Bladder control difficulty</td>
<td>Frequent nose bleeds</td>
<td>Anemia</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>Minor/major surgery</td>
<td>Significant accident/injury</td>
</tr>
<tr>
<td>Head injury/concussions</td>
<td>Bone/orthopedic problems</td>
<td>Other:</td>
</tr>
</tbody>
</table>

If yes, explain: __________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________


Health History (cont.)

Nutrition

Describe what your child eats in a typical day: ______________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
Describe his/her eating habits: ________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Birth History

How far along was the mother when she found out she was pregnant? _____________________________________
Did the mother receive prenatal care? □ Yes □ No
Did the mother smoke or use alcohol during pregnancy? □ Yes □ No If yes, which one? _______________________
How often? _____________________________________________________________________________________
What drugs or medication were taken during pregnancy? ________________________________________________
Did the mother have any illness or difficulties during the pregnancy? □ Yes □ No
Explain: ________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
Labor was: □ Easy □ Normal □ Difficult Delivery was: □ Vaginal □ C-Section
Comments: _____________________________________________________________________________________
_______________________________________________________________________________________________
Any other complications at or right before birth? (Such as oxygen or blood transfusion needed for infant, etc.):
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Early Development

As an infant, did/does your child have any difficulty with any of the following?
□ Feeding □ Allergies □ Colic □ Poor Weight □ Formula intolerance □ Sleeping
Explain: ________________________________________________________________________________________
_______________________________________________________________________________________________

Family Medical History

Is there a family history of any of the following? (Check all that apply and put the relationship of the person to the child)

<table>
<thead>
<tr>
<th>Heart disease/problems - Relation:</th>
<th>Asthma – Relation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizures/Epilepsy – Relation:</td>
<td>Diabetes – Relation:</td>
</tr>
<tr>
<td>TB – Relation:</td>
<td>Other:</td>
</tr>
<tr>
<td>Neurological (nerve) disorders – Relation:</td>
<td>Explain:</td>
</tr>
<tr>
<td>Birth Defects – Relation:</td>
<td></td>
</tr>
</tbody>
</table>

Is there anything else we should know about your child’s health?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

5
Social History

Child’s Name: ______________________________ Date Form Completed: __________________________

In the following area, indicate at what age your child accomplished the tasks/skills:

<table>
<thead>
<tr>
<th>Task/skill</th>
<th>Age</th>
<th>Task/skill</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turned over</td>
<td></td>
<td>Walked alone</td>
<td></td>
</tr>
<tr>
<td>Smiled at parents</td>
<td></td>
<td>Fed self</td>
<td></td>
</tr>
<tr>
<td>Sat alone</td>
<td></td>
<td>Said “no, no” to everything</td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td></td>
<td>Used phrases/sentences</td>
<td></td>
</tr>
<tr>
<td>Said first word</td>
<td></td>
<td>Toilet trained</td>
<td></td>
</tr>
<tr>
<td>Helped with dressing</td>
<td></td>
<td>Dressed alone</td>
<td></td>
</tr>
<tr>
<td>Drank from a cup</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional comments on your child’s development: _______________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Please check those that describe your child:

- Affectionate & loving
- Has temper tantrums
- Doesn’t pay attention
- Has a sense of humor
- Has sleep problems
- Prefers to play alone
- Spins, lines up toys

- Rocks or spins
- Impulsive
- Has fears
- Hold breath
- Creative
- Falls often
- Shares toys

- Demands constant attention
- Well-coordinated
- Difficulty taking turns
- Bangs head repeatedly
- Shows daredevil behavior
- Dislikes change in routine
- Licks or smells non-food items

- Has staring spells
- Avoids attention
- Curious
- Clumsy
- Stubborn
- Avoids eye contact
- Shy or timid

My child’s strengths: ______________________________________________________________________________
My child’s developmental need: _____________________________________________________________________
My child enjoys: __________________________________________________________________________________
My child is bothered by: ___________________________________________________________________________
I am worried about: __________________________________________________________________________________
Do you have concerns or questions regarding your child’s behavior? Describe: ____________________________
_______________________________________________________________________________________________
What activities does your family enjoy doing together? ________________________________________________
_______________________________________________________________________________________________

Relatives or other important people who are a support to your family: _________________________________
_______________________________________________________________________________________________
Social History (cont.)

Professional/programs that have been helpful to your family or that you are currently involved with: ____________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Immediate family history of any of the following or major changes (check all that apply):

<table>
<thead>
<tr>
<th>Alcoholism</th>
<th>Drug dependence</th>
<th>Mental illness</th>
<th>Learning problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Incarceration</td>
<td>Significant illness</td>
<td>Death in family</td>
</tr>
<tr>
<td>Divorce</td>
<td>New sibling</td>
<td>Custody arrangement</td>
<td>Parent currently deployed</td>
</tr>
<tr>
<td>Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________________________

____________________________________________________________________________

Community Resources

Please check all the community resources that your family currently uses or would be interested in getting more information:

<table>
<thead>
<tr>
<th>Use</th>
<th>Info Needed</th>
<th>Community Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF – Temporary Assistance for needy families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHS – Child Welfare/Protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food stamps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health insurance – Medicaid, CHP+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI – Supplemental Security Income</td>
<td></td>
<td></td>
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<tr>
<td>Professional counseling or evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Care/Preschool</td>
<td></td>
<td></td>
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<tr>
<td>Colorado Child Care Assistance Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Partnership for Child Development – Head Start/Early Head Start</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pikes Peak Mental Health/Project Bloom</td>
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<td></td>
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<tr>
<td>CASA – Court Appointed Special Advocate</td>
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<td></td>
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<tr>
<td>GAL – Guardian Ad Litem</td>
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<td></td>
</tr>
<tr>
<td>TESSA (Domestic Violence Prevention)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WIC – Women, Infants and Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private therapy services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military program:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>El Paso County Dept. of Health Program:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental care for your child/family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care for your child/family</td>
<td></td>
<td></td>
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<tr>
<td>Recreational services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting resources</td>
<td></td>
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</tbody>
</table>

____________________________________________________________________________

Person completing form ___________________________ Date ___________________________
2014-2015 FAMILY ECONOMIC DATA SURVEY
FOR AT-RISK FUNDING ELIGIBILITY

PARENT/GUARDIAN INSTRUCTIONS

This survey is used by the Academy School District 20 to maximize available funding from state and federal sources. In many cases, the eligibility for these funds and programs is linked to whether or not your child is currently eligible for free or reduced price meals in the federal child nutrition programs.

This application form will be used by the school district to determine whether the school is eligible for at-risk funding on behalf of the student. By filling out this form, parents are ensuring that the school district will receive the at-risk funding to which it is entitled based on the population of students serviced by the district.

Complete one survey per household at this school if:
• Your household size and income are within the limits on the Income Chart below, or
• Your family receives SNAP of FDPIR benefits (Supplemental Nutrition Assistance Program or Food Distribution Program on Indian Reservations), or
• You have a foster child.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Yearly</th>
<th>Monthly</th>
<th>Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$21,590</td>
<td>$1,800</td>
<td>$416</td>
</tr>
<tr>
<td>2</td>
<td>$29,101</td>
<td>$2,426</td>
<td>$560</td>
</tr>
<tr>
<td>3</td>
<td>$36,612</td>
<td>$3,051</td>
<td>$705</td>
</tr>
<tr>
<td>4</td>
<td>$44,123</td>
<td>$3,677</td>
<td>$849</td>
</tr>
<tr>
<td>5</td>
<td>$51,634</td>
<td>$4,303</td>
<td>$993</td>
</tr>
<tr>
<td>6</td>
<td>$59,145</td>
<td>$4,929</td>
<td>$1,138</td>
</tr>
<tr>
<td>7</td>
<td>$66,656</td>
<td>$5,555</td>
<td>$1,282</td>
</tr>
<tr>
<td>8</td>
<td>$74,167</td>
<td>$6,181</td>
<td>$1,427</td>
</tr>
</tbody>
</table>

For each additional family member add:

$7,511  $626  $145
**2014-2015 Family Economic Data Survey**

**INSTRUCTIONS:** Using the instruction sheet provided, complete the application, sign your name, date, and return application to school.

**Part 1. Student Information.** List all students attending school in the district; provide school and grade information. Check the foster child check box for all students that are the legal responsibility of a welfare agency or court. **If the student has NO INCOME, you MUST check the No Income box.** If the student has income please add the student to the household section below and provide income information.

**Part 2. Supplemental Nutrition Assistance Program (SNAP) /Food Distribution Program on Indian Reservations (FPDIR):**

Provide the name and case number for the person who receives benefits.

(Enter information and skip to part 5)

Name: ____________________________

Case Number: ______________________

**Part 3. Other Source Eligibility:** If any child you are applying for is HOMELESS, MIGRANT, OR RUNAWAY, check the appropriate box to the left and call [your school, homeless liaison, migrant coordinator at phone #]

**Part 4. List all current gross income, and check how often it was received.**

**Part 5. MEDICAID AND/OR STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP):**

The information provided in the application may be shared with Medicaid or SCHIP offices to seek enrollment of children into the above programs. You are not required to consent to the disclosure of this information; this will not affect your student(s)’ eligibility status.

Your information MAY be shared unless you check the box below.

Please do NOT share my information with the Medicaid or SCHIP offices.

**Part 6. Signature:** (Adult MUST sign and date)

An adult household member must sign and date the application.

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school district may get funding based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose benefits, and I may be prosecuted. Sign here: X ______________________ Date: ________________

**DO NOT WRITE BELOW THIS LINE. DISTRICT USE ONLY**

---

**Annual Income Conversion:** Weekly x 52; Bi-Weekly x 26; 2 Times per Month x 24; Monthly x 12

- Total Income: ________ per ________
- Income: ___________ Categorically Eligible App Num: ___________
- Determining Official’s Signature: __________________________ Date: ____________
- Withdrawn Date: ____________