Office of Early Learning
Learn Early. Learn for Life.

EARLY LEARNING COALITION OF SEMINOLE
Good beginnings last a lifetime

For ELC Use Only:
ELC Received Date: ELC _____
Processed Change: _____

School Readiness- Parent Reporting Changes Packet

Submit completed packet AND supporting documentation to the Early Learning Coalition of Seminole in person or place in Drop Box. Changes must be reported within 10 Calendar Days (Chapter 6M-4, Florida Administrative Code). You will be notified by email that submitted changes have been processed by an Eligibility Specialist. DO NOT USE WHITE OUT ON ANY FORMS!

Name:	Phone:
Address:	Email:
I am reporting the following changes on_____(today's date) ☐ I have attached the required documentation. ***[Examples of acceptable documentation listed in bold below]***	

☐ **Income/School Change** Effective Date of Change _____

[ELC of Seminole Employment Verification form AND paystubs for new jobs, medical leave form, school schedule/enrollment verification form, child support report, court order, benefit or award letter (if applicable)are required to be submitted with this packet.}

Who in the family has the change in employment/school/unearned income? _____

☐ Employment:
- ☐ New pay rate is $ _____
- ☐ Work hours:_____per week
- ☐ Begin Maternity/Medical Leave
- ☐ Return to work
- ☐ Loss *(reason)* ***Last Day Worked: ___/___/___***
- ☐ New job Employer Name: _____
- ☐ Second job Employer Name: _____

☐ School Attendance: School Ends ☐ School Starts *(number of credits or hours per week)* _____

☐ Unearned Income: ☐ Child support ☐ Social Security ☐ SSI ☐ Relative Caregiver ☐ TANF
☐ Unemployment Compensation ☐ Other _____
New monthly amount $ _____
Will this be the same next month? ☐ Yes ☐ No, next month $_____

☐ **Family Change** Effective Date of Change _____

[Driver license, birth certificate, marriage license, divorce decree, notarized statement]

☐ Marital Status change to: ☐ Married ☐ Separated ☐ Divorced
☐ Requesting to add a member to the household

Name_____Relationship to you _____

☐ Requesting to remove a member from the household

Name_____Relationship to you _____

New address for this person _____

☐ **Address Change** Effective Date of Change _____

[Current lease, utility bill, landline phone bill, current pay stub, government issued document]

New Address_____City/Zip_____

☐ **Termination of Services Request**

Child Name:_____**Last Day Child Will Attend Services:**_____

Application for Child Care Funding

EARLY LEARNING COALITION OF SEMINOLE
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Using blue or black ink, please complete sections A, B, and C, then sign and date. *Do not use white-out.*

COALITION USE ONLY			
ELIGIBILITY:	Funding Agency	Funding Contract	Eligibility
AUTHORIZATION DATES:	Eligibility Authorized From	Next Redetermination Date	Purpose for Care

A. PARENT/GUARDIAN IDENTIFYING INFORMATION

Applicant Last Name First Name MI				Date of Birth	Gender ☐M ☐F	Race	Social Security Number (optional)
Home Phone Number	Work Phone Number			Email Address			Marital Status
Street Address	City	County	State	Zip			Family Size in Household
Mailing Address (*if different*)	City	County	State	Zip			Primary Language in Home
Other Parent/Guardian Name (*if in household*)				Date of Birth	Gender ☐M ☐F	Race	Social Security Number (optional)

B. CHILDREN REQUIRING CARE

Name of Child Needing Care	*Applicant's Relationship*	*Gender*	*Race*	*U.S. Citizen*	*Social Security Number(optional)*	*Date of Birth*	*Second Parent (if not in household)*	COALITION *Daily Fee FT / PT*
		☐M ☐F		☐Y ☐N			Name: City: State:	
		☐M ☐F		☐Y ☐N			Name: City: State:	
		☐M ☐F		☐Y ☐N			Name: City: State:	
		☐M ☐F		☐Y ☐N			Name: City: State:	

C. OTHER HOUSEHOLD MEMBERS

Name	*Date of Birth*	*Gender*	*Race*	*Relationship to Applicant*	*Relationship to Children Above*
		☐M ☐F			
		☐M ☐F			

You have the right to apply for assistance and to have a determination of your eligibility without regard to race, sex, age, disability, religion, national origin, ethnic background, marital status or political belief. If you have a disability that substantially limits your access to the ELC, please inform us so that reasonable accommodations can be made that do not cause you undue burden or hardship.

PRIVACY ACT STATEMENT: Social Security numbers are requested on this form under s.119.071 (5)(a)2., F.S., for the use in the records and data system of the Florida Office of Early Learning and Early Learning Coalitions. Social Security numbers will be used for routine data requests, state and federal reporting requirements, identification, and to verify eligibility for the School Readiness Program, including, but not limited to family income. Submission of social security numbers on this form is voluntary and not a condition of enrollment in the School Readiness Program.

I certify that the above information is true and complete to the best of my knowledge.

Client Signature _____ Date _____

ELC Eligibility Specialist _____ Date _____

United Way

OFFICE OF Early Learning
LEARN EARLY. LEARN FOR LIFE.

FL OFFICE OF EARLY LEARNING

INCOME WORKSHEET FOR APPLICATION FOR SUBSIDIZED CARE

Funder : OFFICE OF EARLY LEARNING

Complete the Following Information about family members who work

Eligibility :

Name of Person Working	Employer's Name Address Telephone Number	How Often Paid	Gross Earnings	Weekly Work Schedule		
			Amount	Day of Week	From	To
(Parent on whom eligibility is determined)						
	Name of Employer: Address : Phone No:	☐ Weekly ☐ Bi-Weekly ☐ Semi Monthly ☐ Monthly ☐ Annually		Monday		
				Tuesday		
				Wednesday		
				Thursday		
				Friday		
				Saturday		
				Sunday		
(Other Spouse living in the home)						
	Name of Employer: Address : Phone No:	☐ Weekly ☐ Bi-Weekly ☐ Semi Monthly ☐ Monthly ☐ Annually		Monday		
				Tuesday		
				Wednesday		
				Thursday		
				Friday		
				Saturday		
				Sunday		
Education:	Name/Address/Telephone of School:					
				Monday		
				Tuesday		
				Wednesday		
				Thursday		
				Friday		
				Saturday		
				Sunday		

If any family member receives any of the following type of unearned income (or benefits), check the type of benefits received. Where the space is provided, enter the case or account number and the amount received. If child support or alimony is paid to another household, enter case number, amount paid and family member making payment.

Type of Unearned Income	Have it?	Case/Account Number	Amount	Name of Family Member Receiving Inc.	Include?
ADOPTION BENEFITS					
ALIMONY					
CHILD SUPPORT (RECEIVED)					
CHILD SUPPORT (PAID OUT)					
EMPLOYMENT					
FOOD STAMPS (EXEMPT)					
HOUSING ASSISTANCE (EXEMPT)					
INTEREST/DIVIDENDS					
MILITARY HOUSING (EXEMPT)					
RETIREMENT BENEFITS (INCLUDING SOCIAL SECURITY BENEFITS)					
SOCIAL SECURITY INCM (SSI)					
SOCIAL SEC (DISABILITY INCOME)					
ASSISTANCE/TANF CASH ASSITANCE					

UNEMPLOYMENT (RE-EMPLOYMENT ASSISTANCE)					
VETERAN BENEFITS					
WORKER'S COMP					

I hereby certify that the information given in this worksheet is true and complete to the best of my knowledge. I understand that if I knowingly give wrong information, I may be liable for prosecution under state law, and that School Readiness services may be terminated. I also understand that if any changes occur to the information on this worksheet, I will notify the coalition of those changes within ten (10) days of occurrence. I certify under the penalty of perjury (a first degree misdemeanor punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding $1,000 pursuant to s. 837.012, or 775.082, or 775.083, F.S.) I fully understand that any omissions, falsifications or misrepresentations may disqualify my child(ren) from receiving child care scholarship and that I may be liable for prosecution under the full strength of the law plus repayment of ineligible child care services.

Family Size:_____ Total Income: $_____ Fee Assessed: $_____

Signature of Parent: _____ Date: __/__/__

Signature of Counselor:_____ Date:__/__/__

Employment/Income Verification Form

In order to determine eligibility for a child care scholarship, the ELC must receive copies of the **most current consecutive six weeks** pay stubs or this form, completed by the employer, as documentation of a new job or if paystubs are not issued. ***Do Not Use White Out! Any form containing White Out will not be accepted.***

SECTION I – GENERAL INFORMATION: (To be completed by employer)

1. Employee Name: _____ SS#_____

   Employee Address: _____

2. Type of work performed by employee: _____ Employment began:_____

3. Number of hours worked: Per week: _____ Number of days per week: _____

   Work schedule: From: _____ To: _____ ☐ A.M. ☐ P.M.

   Circle Days of Work: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

4. Hourly wage received by employee: $_____ Date employment ended: _____

5. Employee paid: $_____ ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other

6. Does employee receive tips? ☐ Y ☐ N If Yes, show tips in Section III

7. Is employment year-round? ☐ Y ☐ N If No, specify # of months: ☐ 12 ☐ 11½ ☐ 11 ☐ 10½ ☐ 10 ☐ 9½ ☐ 9 ☐ Other: _____

SECTION II – EMPLOYER INFORMATION: (To be completed by employer)

1. Employer Name: _____ Title: _____

2. Business Name: _____ Phone #: _____

3. Business Address: _____

SECTION III – RECORD OF PAY RECEIVED: (To be completed by employer)

1. In the space below, list the most current and consecutive **SIX** weeks of checks or cash received by the employee along with the gross amount paid, hours worked and the date the checks or cash were issued.

DATES OF PAY PERIOD	DATE OF PAYMENT	GROSS EARNINGS	# OF HOURS WORKED	TIPS	NET PAY

2. Please explain any unusual gaps or overtime and do you expect them to reoccur? _____

   _____

SECTION IV – EMPLOYER VERIFICATION:

I certify under the penalty of perjury (a first degree misdemeanor punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding $1,000 pursuant to s. 837.012, or 775.082, or 775.083, F.S.) the information provided on this form is true and complete to the best of my knowledge. I know if I give false information on purpose, I may be subject to prosecution for fraud.

_____ _____

Employer Signature Title Employer Name (Print or Type) Date