



GSRP Preschool Application 2024-2025

These materials were developed under a grant awarded by MiLeap
YMCA at Northside Child Development Center
2020 N. 5th Street Niles, Michigan 49120

Child's Name: _____

Please check classroom preference:

- Monday-Thursday full day 8:20 AM-3:20 PM
 - Monday-Thursday 1/2 Day 8:20 AM-12:00 PM
 - Monday-Friday full day 8:20 AM-3:20 PM
- Seats are limited and distributed as a first come, first serve.*

Turn in the following items with your application packet:

- Proof of Age:** Such as a Birth Certificate, passport, immigration record or baptismal certificate. Your child must be 4 by September 1. (Consideration for children who turn 4 from September 2-December 1)
- Proof of Income:** Such as work earnings (W-2, tax return, or check stubs), child support, unemployment, SSI, cash assistance and any other proof of income
- Proof of Residency:** Such as driver's license, rent receipt, utility bill, letter from shelter or host if between homes. You must live in Berrien County **or** Cross-County families will need to complete a Cross County Prior Approval form
- If your child has an IEP** (Individual Education Plan) please include a copy
- Completed copy of the Health and Immunization form** (included in this packet): **To be completed prior to your child starting GSRP.** This document will be completed from your child's doctor's office.
- Transportation form:** Residence must be within the Niles Community School District to be eligible for transportation.



2024-2025	Head Start	Head Start	GSRP	GSRP	GSRP	GSRP	Tuition enroll on/after Sept. 1
Household Size	0-50%	51-100%	101-150%	151-200%	201-250%	251-300%	301-400%
1	0-7,530	7,531-15,060	15,061-22,590	22,591-30,120	30,121-37,650	37,651-45,180	45,181-60,240
2	0-10,220	10,221-20,440	20,441-30,660	30,661-40,880	40,881-51,100	51,101-61,320	61,321-81,760
3	0-12,910	12,911-25,820	25,821-38,730	38,731-51,640	51,641-64,550	64,551-77,460	77,461-103,280
4	0-15,600	15,601-31,200	31,201-46,800	46,801-62,400	62,401-78,000	78,001-93,600	93,601-124,800
5	0-18,290	18,291-36,580	36,581-54,870	54,871-73,160	73,161-91,450	91,451-109,740	109,741-146,320
6	0-20,980	20,981-41,960	41,961-62,940	62,941-83,920	83,921-104,900	104,901-125,880	125,881-167,840
7	0-23,670	23,671-47,340	47,341-71,010	71,011-94,680	94,681-118,350	118,351-142,020	142,021-189,360
8	0-26,360	26,361-52,720	52,721-79,080	79,081-105,440	105,441-131,800	131,801-158,160	158,161-210,880
For each additional family member add	2,690	5,380	8,070	10,760	13,450	16,140	21,520

Please note - Acceptance into a GSRP classroom does not guarantee that you will be accepted into that school's Kindergarten or Young 5's program, you will have to follow the process or school of choice process per school. All referrals for speech or special education services are required to be held with your local resident school districts.



BERRIEN COUNTY GSRP APPLICATION 2024-2025

By completing an application this doesn't automatically enroll you into GRSP. All applications/enrollments are pending per review of qualifications and the state GSRP budget. All final notifications will come from teachers/sites prior to the fall start.

PROGRAM PREFERENCE

- BH Charter
 BH Discovery Enrichment Center
 BH/Lylabugs & Buttons
 BH/The Blessed Noahs Ark
 Berrien Springs
 Berrien Springs/Trinity Lutheran
 Brandywine
 Bridgman/Immanuel Lutheran
 Buchanan Public School
 Coloma
 Eau Claire
 Niles/YMCA
 Niles/The Children's Center
 Saint Joseph/The Children's Center
 Saint Joseph/BH YMCA
 Watervliet

CHILD INFORMATION

Child's Legal Name: _____ Date of Birth: ____/____/____
First Name Middle Name Last Name mm dd yyyy

Gender: Male Female

Ethnicity: Hispanic or Latino Yes No

Race: American African American or Black Indian or Alaska Native Asian Hispanic
 Native Hawaiian or Pacific Islander Caucasian or White Two or more races _____

Address _____ City _____ Zip _____ County _____

Phone Number: _____ School District of Residence: _____

FAMILY INFORMATION

Child lives with: Both Parents Mother Father Joint Custody (If joint, Physical or Legal, Explain) _____
 Legal Guardian Grandparents Foster Care Other: Explain _____

Parent/guardian Name 1: _____
 Parent/guardian date of birth: _____
 Address: (if different from above): _____
 Current Employer: _____
 Employers Address: _____
 Primary Phone#: _____
 Alternative Phone#: _____
 Email: _____

Parent/guardian Name 2: _____
 Parent/guardian date of birth: _____
 Address: (if different from above): _____
 Current Employer: _____
 Employers Address: _____
 Primary Phone#: _____
 Alternative Phone#: _____
 Email: _____

EMERGENCY CONTACTS other than parent/guardian

- | | | | | | | |
|----|------|----------------|------|-------|--------------|-----------------------|
| 1. | | | | | | |
| | Name | Street Address | City | State | Phone Number | Relationship to child |
| 2. | | | | | | |
| | Name | Street Address | City | State | Phone Number | Relationship to child |

RISK FACTORS (Please mark all that apply)

01: Income: Annual Gross Income: \$_____ # in your household_____

02: Diagnosed disability or identified developmental delay

- My Child has been referred or diagnosed with a disability/delay by a provider
- My Child has an IEP (IEP will need to be provided with application)

03: Severe or challenging behavior

- My child has been excluded/expelled from other preschool/child care programs
- My child has social services or medical referrals for behavior
- Other:

04: Primary and/or home language other than English

- Primary and/or home language is other than English _____

05: Parent/Guardian with low educational attainment

- One or both parents have no High School diploma or GED Certificate

06: Abuse/Neglect of the child or parent

- There has been abuse/neglect for the child or parent

07: Environmental risk

- There has been parental loss due to death, divorce, incarceration, military service or absence
- There has been sibling issues that have impacted my child
- I was under 20 when my first child was born
- Family is homeless (please mark all that apply below)
 - Doubled up: Sharing housing with others due to loss of housing, economic hardship, etc.
 - Lack of adequate accommodations: Living in a motel, hotel, car, park, campground (public or private place not designed for regular sleeping) or accommodations are inadequate (water, heat, space, etc)
 - Transitional Housing: Living in emergency transitional shelters/housing
 - Foster Care: awaiting placement (for 6 months from the date of placement)
 - Migrant: Migratory children living in any circumstances listed above
 - By marking any of the above homeless situations I understand I qualify for McKinney Vento Services and will be referred onto the District Homeless Liaison

08: None

- My child has none of the risk factors listed above

Parent/Guardian Signature_____ Date_____

FOR OFFICE USE ONLY FOR POWERSCHOOL STAFF: Teachers/Staff must complete this section

Teacher:_____ Start Date:_____ End Date:_____ Child's Name:_____

% FPL: Quintile:

- 01 0-50%
- 02 51-100%
- 03 101-150%
- 04 151-200%
- 05 201-250%
- 06 251-300%(These families must pay for GSRP Tuition and considered after September 1st)
- 07 301-and above% (These families **do not qualify for GSRP**)

Eligibility Factors:

- 02 Diagnosed disability or identified developmental delay
- 03 Severe or challenging behavior
- 04 Primary and/or home language other than English
- 05 Parent/Guardian with low educational attainment
- 06 Abuse/Neglect of the child or parent
- 07 Environmental risk
- 08 None

Qualifying factors

- A Homeless (these families are Quintile 01: 0-50%)
- B Foster Care (these families are Quintile 01: 0-50%)
- C Qualifying IEP (these families are Quintile 01: 0-50%)
- D None

Application Prioritization Rank#_____

Quintile:_____ #of Risk Factors:_____

_____Family qualifies for HS: approved to be served in GSRP



2024-2025 Income/Age/Resident/IEP Verification Form

Berrien County GSRP Program

Child's Name: _____ Parent(s) Name: _____

Income Source Verification	Amount Received			
	Documentation provided	Annually	Monthly	Weekly
Income tax Form 1040				
W-2				
TANF documentation				
Pay Stub or Pay Envelopes				
Unemployment				
Written statement from employer(s)				
Foster Care Reimbursement				
SSI documentation				
Child Support				
Alimony				
Pension(s)				
Other				
Documentation of no income				

Total of Income Documented Above: \$ _____ Number in Household: _____

I verify that I have provided true and accurate documentation as indicated above.

Parent/Guardian Signature

Date of Verification

FOR OFFICE USE ONLY

I verify that I have reviewed the following documentation with the families:

- Proof of Age:** Such as a Birth Certificate, passport, immigration record or baptismal certificate
- Proof of Income:** Such as work earnings (W-2, tax return, or check stubs), child support, unemployment, SSI, cash assistance and any other proof of income.
- Proof of Residency:** Such as driver's license, rent receipt, utility bill, letter from shelter or host if between homes.
- If a child has an IEP** (Individual Education Plan) copy has been reviewed

GSRP Staff Signature

Date of Verification



PERMISSION FORM FOR OUTSIDE SCREENING/SERVICES

Child's Name _____ School/Site _____

I _____ (parent/guardian name) give permission for _____ (child's name) to receive the following services outside of the GSRP classroom.

The following screening/services may be provided:

- Speech screening and/or services
- OT screening and/or services
- PT screening and/or services
- Vision screening and/or services
- Hearing screening and/or services
- Kindergarten screening
- Other _____

I am aware that all school staff and volunteers receive a background check and understand it is not the same comprehensive check as the GSRP teachers. I understand that my child will be screened or provided services outside of the GSRP classroom.

Please check one of the responses listed below and sign and date the form in the space provided:

Yes, I give permission for the screening (s) and/or service (s)

No, I do not give permission for the screening (s) and/or service (s)

Parent/Guardian Signature

Date



GSRP Underage Consideration

******Only complete if your child will turn 4 after September 1 - December 1******

GSRP Underage Eligibility Consideration-Special Circumstances for Children turning 4 **after** September 1st - December 1st.

I understand that a child who turns 4 years old **after** September 1st - December 1st can be considered for enrollment in the Free Preschool in Berrien County by requesting this Special Consideration.

I also understand that the intention of the Great Start Readiness Preschool program is to be provided the year before a child enters kindergarten, therefore I am requesting that eligibility for enrollment into a Great Start Readiness Preschool program be considered for my child because I plan to request early entry into kindergarten the following year.

_____ and _____
Child's full name Date of Birth

I understand that this does not guarantee my child a classroom placement in GSRP for the school year and that I will be notified of the enrollment status after **September 1**.

_____ Date
Parent Signature

Teacher: _____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:		Date of Admission	Date of Discharge
Name of Child (Last, First, Middle Initial)			Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State
		Zip Code	
Parent/Legal Guardian's Name	Primary Phone ()	Parent/Legal Guardian's Name (Optional)	Primary Phone ()
Home Address (if not child's address)	2 nd Phone (if applicable) ()	Home Address (if not child's address)	2 nd Phone (if applicable) ()
City	State	Zip Code	
Email Address (optional)		Email Address (optional)	
Employer Name	Work Phone ()	Employer Name	Work Phone ()
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ()	
Hospital Preferred for Emergency Treatment (optional)			
Allergies, Special Needs and/or Special Instructions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)			

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See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)		
1.	()	()
2.	()	()
3.	()	()
Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)		
1.	()	2. ()
3.	()	4. ()

Parent/Legal Guardian Initials:
_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.	
Signature of Parent or Guardian	Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials
LARA is an equal opportunity employer/program.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)	DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street) (City) (ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)	HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street) (City) (ZIP Code) MI	WORK TELEPHONE NUMBER ()

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	
			Parent/Guardian Signature _____	
			Date _____	

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Height Weight Other: _____					
			Muscle Imbalance											
			Other: _____											
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT	⇒				
			Other: _____											
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / / Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm	Type: _____				
			Albumin											
			Microscopic											
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.							

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

SECTION III - IMMUNIZATIONS					
Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*					
VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			Influenza (IIV/LAIV)	1
DTaP/DTP/DT/Td	1	4	2		4
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6		Human Papillomavirus (HPV9/HPV4/HPV2)	1
Tdap	1		2		
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
	2	4	3		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	2	4	*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
Rotavirus (RV1/RV5)	1	3			
	2				
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____ / _____ / _____ <i>Health Professional's Signature</i>			_____ / _____ / _____ Title		_____ / _____ / _____ Date

		SECTION IV - RECOMMENDATIONS
		(Required for Child Care and Head Start/Early Head Start)
No	Yes	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other

Other Recommendations		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)
I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ child's name

_____ / _____ / _____ <i>Dentist's Signature</i>
_____ / _____ / _____ Date

PHYSICIAN'S SIGNATURE			
_____ / _____ / _____ <i>Examiner's Signature</i>	Date	_____ / _____ / _____ <i>Examiner's Name (Print or Type)</i>	Degree or License
_____	_____	_____ MI _____	_____ (_____) _____ Telephone
Number & Street	City	ZIP Code	

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.



**STUDENT TRANSPORTATION INFORMATION FORM
NORTHSIDE SCHOOL ONLY**

DATE FORM COMPLETED: _____ COMPLETED BY (PRINT): _____

STUDENT NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ OTHER PHONE: _____

PARENT/GAURDIAN NAME: _____

AM ADDRESS: _____

PM ADDRESS: _____

CHILD CARE PROVIDER NAME: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

SIGNATURE OF PERSON COMPLETING FORM: _____

TRANSPORTATION & SCHOOL OFFICE USE ONLY

New or Existing Student (Circle one) Student ID: _____ Program: GSRP

Gen or ECSC (Circle one) AM FULL (Circle one) MON-THURS OR MON-FRI (Circle one)

AM Route: _____ PM Route: _____ Stop Location: _____

AM Time: _____ PM Time: _____ Processed by: _____

Driver Notified: ____ Parent Notified: ____ School Notified: ____ Date to Start: _____