FY 20 - 21 PHLpreK Child File Document Order

Subject

- **2020 - 2021 PHLpreK Application***
- **Proof age and residency documentation***
- **Screening, Assessment, Data Sharing Release Form**
- **Emergency contact form**
- **Parent Agreement**
- **Dental Provider Consent Form (optional)**
- **Ready4K Consent Form (optional)**
- CCIS verification (if applicable)?
- Health assessment?
- Kindergarten transition plan (if applicable)?
- Developmental screening (ASQ 3 and ASQ SE)?
- Evidence of referral for services (if applicable)?
- Outcomes assessment (print copy of the assessment status and documentation status reports)?

***Required for payments**

School Year 2020-2021
PHLpreK Application

This is an application for PHLpreK, the City of Philadelphia's pre-kindergarten program for 3 and 4 year old's. By completing this application, you are applying to participate in the program at an eligible and participating early learning program provider. For the list of participating PHLpreK providers please visit www.phlprek.org or call 844-PHL-PREK.

PHLpreK is funded by the Philadelphia Beverage Tax.

About PHLpreK Eligibility

The only eligibility requirements for PHLpreK participation during the 2020-2021 School Year are:

- *Child must be 3 or 4 by September 1, 2020*
- *Family must reside in Philadelphia*

Information gathered in this application will assist the PHLpreK team in connecting PHLpreK families with services, resources, and benefits. Information gathered in this application will also be used to understand more about the families that are accessing PHLpreK and to identify additional resources needed in the community for families with young children.

Personal identifying information included in this application will remain confidential and Child/Family Contact information will only be used by PHLpreK Staff to communicate with families about PHLpreK.

Application Questions

Child Information

Child's First Name: _____ Child's Middle Name: _____

Child's Last Name: _____

Child's Street Number and Street Name: _____

City: _____ State: _____ Zip code: _____

Does the child currently live in a shelter, transitional housing, or share housing? (**Check one)**

□ Yes □ No

Child's Date of Birth: Month _____ / Day _____ / Year _____

Child's Gender **(check one)**: □ Male □ Female □ Other

Has your child previously received childcare services? **(check one)** ☐ Yes ☐ No

Is your child currently receiving Early Intervention services? **(check one)** ☐ Yes ☐ No

Does your child have a current IFSP or IEP? **(check one)** ☐ Yes ☐ No

Family Information

Caregiver One

Parent/Guardian's First Name: _____

Parent/Guardian's Last Name: _____

Parent/Guardian's Relationship to Child: _____

Parent/Guardian's Phone Number: _____ □ Cell □ Home □ Work

Parent/Guardian's Email Address: _____

Caregiver Two

Parent/Guardian's First Name: _____

Parent/Guardian's Last Name: _____

Parent/Guardian's Relationship to Child: _____

Parent/Guardian's Phone Number: _____ □ Cell □ Home □ Work

Parent/Guardian's Email Address: _____

Custody Agreement

The program will presume that there are no restrictions regarding a parent/guardian's right to be kept informed of his/her student's school progress and participate in school activities. A parent/guardian will only be prevented from participating in his/her student's education if a signed court order (e.g. divorce decree, custody order, or restraining order) specifically restricts the parent/guardian's access to the student. If restrictions are in place, the parent/guardian with legal custody must submit a signed copy of the court order describing the rights restricted.

Is there a custody agreement for this child that we need to be aware of: (check one) ☐ Yes ☐ No

**** If yes, please provide a copy of the Custody Agreement.**

Based on the Custody Agreement please specify who should be contacted for the following reasons:

- ☐ Enrollment and Discharge: _____
- ☐ Attendance and Program Calendar: _____
- ☐ Curriculum, Child Progress, Child Records: _____

- Program Activities, Meetings and Policies: _____
- Incident, Illness, and Emergency Contact: *_____

*The site will request you to complete an emergency contact to gather more information.

Demographic Information

****Primary household refers to where the child lives**

Primary household language: _____

Secondary household language: _____

Child's race **(check one)**:

□ American Indian/Alaska Native □ Asian

□ Black/African American □ Multi-racial

□ Native Hawaiian/Pacific Islander □ White/Caucasian

□ Other: _____

Child's ethnicity (check one):

□ Hispanic/Latino □ Non-Hispanic/Latino

Number of people in household where the child lives (Please include everyone living in this household): _____

**Annual household income does not determine eligibility for the PHLpreK program. This information is asked for statistical purposes only.*

Income in the past 12 months***** Provide the best estimate of the **TOTAL AMOUNT** of income received jointly by all members in the household where the child lives during the **PAST 12 MONTHS** *(total amount for past 12 months).*

The **TOTAL AMOUNT** of income includes wages, salary, retirement income, public assistance payments and/or self-employment income.

$ ☐☐☐,☐☐☐.00

TOTAL AMOUNT for past 12 months

□ Prefer not to disclose

In what type of industry does the parent/guardian primarily work? (check all that apply)

□ Education □ Health care □ Federal, state, or local government

□ Financial services □ Transportation services □ Retired □ Other: _____

Service Information

**Information gathered in this section will be used to identify what additional resources families in the PHLpreK system may need. Please complete the section fully.*

Service Day: **(check one)** □ Part-day (5.5 hours) □ Full day (over 5.5 hours)

Service Year: **(check one)** □ School year (180 days) □ Full year (260 days)

****PHLpreK only covers 5.5 hours of Instructional Time.***

If **full-day** or **full year**, please indicate what the supplemental funding source is for the time beyond that funded by PHLpreK:

□ Child Care Works subsidy □ Private pay □ Other, please specify: _____

Provider Preference Information

**Information gathered in this section will be used to identify the priorities of families in the PHLpreK system and is used to make decisions about the location of PHLpreK seats. Please complete the section fully.*

How many **hours a day** would you prefer your child to attend the early learning program? _____

If you are seeking to enroll your child for more than the number of hours PHLpreK provides to you free of charge **how much** would you be willing to pay for care (**per month**)? _____

Are you seeking to enroll a sibling of your child in an infant/toddler program? ☐ Yes ☐ No

Are you seeking to enroll a sibling of your child in a school age program? ☐ Yes ☐ No

How are you planning to travel to your child's early learning program? **(Check all that apply)**

□ Drive and/or have someone else drive me
□ Bus and/or trolley
□ Market Frankford Line/Broad Street Line
□ Regional Rail
□ Walk
□ Other, please describe: _____

How many minutes are you willing to travel to your child's early learning program? (Check one)

□ 1-15 minutes □ 16-30 minutes □ 31-45 minutes □ More than 45 minutes

If distance/convenience was a factor in choosing this location, which factor was more important? **(Check one)** □ Close to home □ Close to work/school

What would you say are your **TOP THREE** priorities when choosing an early learning program for your child? (**Check three** from the list below)

□ Affordability
□ School readiness/academic curriculum
□ Safe environment
□ Feeder program with an elementary school
□ Meals provided
□ Keystone STARs quality rating

□ Outdoor play space provided
□ Infant care provided
□ Other social services provided
□ Personal referral/word of mouth
□ Siblings already enrolled at the center
□ Other, please describe: _____

How did you hear about the PHLpreK program? **(Please check all that apply)**

□ SEPTA advertisement □ Community leader □ PHLpreK website □ Friend/family member
□ Newspaper advertisement □ Doctor's office □ Child Care Works mailing □ The School District
□ Social media □ News story □ Radio advertisement □ Other: _____

Eligibility Attestation

I, as a PHLpreK provider, attest that this child is a resident of Philadelphia, is 3 or 4 years old on September 1, 2020 (and not of kindergarten entry age on September 1, 2020), and has been referred to ELRC to determine eligibility for other services. I confirm that all verification documentation (birthdate and residency) is maintained on file at the site location.

_____ _____ _____
Name of staff (print) Title Date

_____ _____
Signature of Staff Name of PHLpreK Program

By signing this form, parent/guardians of PHLpreK children agree to notify their PHLpreK provider within 15 days if the family moves outside the city limits of Philadelphia. If families move outside of Philadelphia, they are **no longer eligible** for the PHLpreK program.

Please **initial here** if you, as a PHLpreK parent/guardian, agree to receive text messages from the PHLpreK team: _____
Provide the Phone Number where you agree to receive text messages: _____

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

School Year 2020-2021
PHLpreK Application

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Personal identifying information included in this application will remain confidential and Child/Family Contact information will only be used by PHLpreK Staff to communicate with families about PHLpreK.

Application Questions

Child Information

Must complete this section to it's entirety

Child's First Name: _____ Child's Middle Name: _____

Child's Last Name: _____

Child's Street Number and Street Name: _____

City: _____ State: _____ Zip code: _____

Does the child currently live in a shelter, transitional housing, or share housing? (**Check one)**

□ Yes □ No

Child's Date of Birth: Month _____ / Day _____ / Year _____

Child's Gender **(check one)**: □ Male □ Female □ Other

Has your child previously received childcare services? **(check one)** □ Yes □ No

Is your child currently receiving Early Intervention services? **(check one)** □ Yes □ No

Does your child have a current IFSP or IEP? **(check one)** □ Yes □ No

Family Information

Must complete this section to it's entirety

Caregiver One

Parent/Guardian's First Name: _____

Parent/Guardian's Last Name: _____

Parent/Guardian's Relationship to Child: _____

Parent/Guardian's Phone Number: _____ □ Cell □ Home □ Work

Parent/Guardian's Email Address: __If families do not have an email state this here_____

Caregiver Two

Parent/Guardian's First Name: _____

Parent/Guardian's Last Name: _____

Parent/Guardian's Relationship to Child: _____

Parent/Guardian's Phone Number: _____ □ Cell □ Home □ Work

Parent/Guardian's Email Address: __If families do not have an email state this here_____

Custody Agreement

Complete this section, If applicable

The program will presume that there are no restrictions regarding a parent/guardian's right to be kept informed of his/her student's school progress and participate in school activities. A parent/guardian will only be prevented from participating in his/her student's education if a signed court order (e.g. divorce decree, custody order, or restraining order) specifically restricts the parent/guardian's access to the student. If restrictions are in place, the parent/guardian with legal custody must submit a signed copy of the court order describing the rights restricted.

Is there a custody agreement for this child that we need to be aware of: (check one) □ Yes □ No

**** If yes, please provide a copy of the Custody Agreement.**

Based on the Custody Agreement please specify who should be contacted for the following reasons:

- □ Enrollment and Discharge: _____
- □ Attendance and Program Calendar: _____
- □ Curriculum, Child Progress, Child Records: _____
- □ Program Activities, Meetings and Policies: _____

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*The site will request you to complete an emergency contact to gather more information.

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****Primary household refers to where the child lives**

Primary household language: _____

Secondary household language: _____

Child's race **(check one)**:

□ American Indian/Alaska Native
□ Asian
□ Black/African American
□ Multi-racial
□ Native Hawaiian/Pacific Islander
□ White/Caucasian
□ Other: _____

Child's ethnicity (check one):

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Number of people in household where the child lives (Please include everyone living in this household): _____

**Annual household income does not determine eligibility for the PHLpreK program. This information is asked for statistical purposes only.*

Income in the past 12 months***** Provide the best estimate of the **TOTAL AMOUNT** of income received jointly by all members in the household where the child lives during the **PAST 12 MONTHS** *(total amount for past 12 months).*

The **TOTAL AMOUNT** of income includes wages, salary, retirement income, public assistance payments and/or self-employment income.

Families are encouraged to complete this section, if they choose not to disclose, please ensure this is checked off

$ □□□,□□□.00

TOTAL AMOUNT for past 12 months

□ Prefer not to disclose

Check off if it applies to a caregiver

In what type of industry does the parent/guardian primarily work? (check all that apply)

□ Education □ Health care □ Federal, state, or local government
□ Financial services □ Transportation services □ Retired □ Other: _____

Service Information

Must complete this section to it's entirety

**Information gathered in this section will be used to identify what additional resources families in the PHLpreK system may need. Please complete the section fully.*

Service Day: **(check one)**
□ Part-day (5.5 hours)
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****PHLpreK only covers 5.5 hours of Instructional Time.***

Service Year: **(check one)**
□ School year (180 days)
□ Full year (260 days)

If **full-day** or **full year**, please indicate what the supplemental funding source is for the time beyond that funded by PHLpreK:

□ Child Care Works subsidy □ Private pay □ Other, please specify: _____

Provider Preference Information

Parents should complete what applies, this allows us to gather information to understand what is most important for families when choosing a location.

**Information gathered in this section will be used to identify the priorities of families in the PHLpreK system and is used to make decisions about the location of PHLpreK seats. Please complete the section fully.*

How many **hours a day** would you prefer your child to attend the early learning program? _____

If you are seeking to enroll your child for more than the number of hours PHLpreK provides to you free of charge **how much** would you be willing to pay for care (**per month**)? _____

Are you seeking to enroll a sibling of your child in an infant/toddler program? □ Yes □ No

Are you seeking to enroll a sibling of your child in a school age program? □ Yes □ No

How are you planning to travel to your child's early learning program? **(Check all that apply)**

□ Drive and/or have someone else drive me
□ Bus and/or trolley
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How many minutes are you willing to travel to your child's early learning program? (Check one)

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If distance/convenience was a factor in choosing this location, which factor was more important? **(Check one)** □ Close to home □ Close to work/school

What would you say are your **TOP THREE** priorities when choosing an early learning program for your child? (**Check three** from the list below)

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□ Outdoor play space provided

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□ Keystone STARs quality rating

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How did you hear about the PHLpreK program? **(Please check all that apply)**

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_____ _____ _____

Name of staff (print) Title Date

_____ _____

Signature of Staff Name of PHLpreK Program

Provider must sign attesting to verifying age and residency and add program name

By signing this form, parent/guardians of PHLpreK children agree to notify their PHLpreK provider within 15 days if the family moves outside the city limits of Philadelphia. If families move outside of Philadelphia, they are **no longer eligible** for the PHLpreK program.

Please **initial here** if you, as a PHLpreK parent/guardian, agree to receive text messages from the PHLpreK team: _____

Provide the Phone Number where you agree to receive text messages: _____

Text messaging services is optimal for families

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Parent must sign and date the application

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME	BIRTH DATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $	PER MIN-HR	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

Screening, Assessment, and Data Sharing Release Form
2020-2021 School Year

Child's Name	
Child's DOB	
Child's Address	
Parent/Guardian Name	
Provider (Site Location) Name	

Developmental Screenings

Childcare programs funded by PHLpreK offer on-site **developmental screenings** for children enrolled in the program. The **purpose** of the screening is to determine whether your child's development corresponds to what is typically expected for a child at his or her age. The classroom teachers administer this screening utilizing the **Ages and Stages Questionnaire (3 and SE)** to access what skills your child has achieved and identify areas which may need additional support. If the tool suggests a **re-screen** the teacher will conduct this activity at a later date, which is initiated by the screening recommendations. If a more complete evaluation is indicated, a referral to the appropriate Early Learning Agency will be recommended and you will be informed and guided through the process.

Outcomes Assessments

Additionally, the childcare programs funded by PHLpreK complete **outcomes assessments** (2 times a year at minimum) for each child. The assessment is completed through an on-line database, which keeps the child's information confidential and secure. The outcomes assessments are used to determine what teachers need to focus on to support learning objectives for school readiness through their lesson planning.

Additional Services

Based on the results indicated in the screenings and or outcome assessment children may **need a referral** to the Local Education Agency (ELWYN) for Early Intervention. The PHLpreK system has supports to help families navigate the process to access additional specialized services when children need them. Some children may also enroll into the PHLpreK program with a current Individualized Education Plan and the data collected by the (LEA) is useful to support classroom planning based on the specific goals outlined for the child.

The information collected through the screening tools, outcomes assessments, and any information received by Local Education Agency (ELWYN) allows the PHLpreK program to support the child's development and it **is also useful to guide decisions about the structure of the PHLpreK program and it's supports to families and early childhood providers.**

*By **signing and initialing** this document, you acknowledge permission to PHLpreK to complete the screenings, outcomes assessment, and allow data sharing with the Local Education Agency if a referral is made or the child has an active IEP.*

_____ Developmental Screening (3 & SE) _____ Child Outcomes Assessment

_____ Sharing Individualized Education Plan and Referral Data

_____ _____

Parent/Guardian Signature Date

If you have any questions about the resources described in this document, please discuss these with the site's administration. If you still have further questions that could not be answered you can contact PHLpreK at 267-773-4432.

ORAL HEALTH IMPACT PROJECT

THE DENTIST IS COMING TO YOUR SCHOOL!

Our school has joined with the **Oral Health Impact Project** to offer in-school Dental Care at ***NO COST* to you.***

Taking Care of your child's teeth is important to keep them healthy.

EASY & CONVENIENT - A state licensed dentist will regularly check your child's mouth & teeth, as well as provide a cleaning, x-rays as necessary, fluoride treatment and apply sealants, as needed. Additional care, such as fillings, may also be provided. A dental report card will be sent home with your child. Includes initial dental care & follow-up visits. **SIGN AND RETURN TO YOUR SCHOOL TODAY!**

PLEASE COMPLETE

Child's Legal Name		Birth Date	☐ Male ☐ Female
Address	City	State	Zip
School	Teacher		Grade
Parent/Guardian Name		Phone ( )	
Email		Alt Phone ( )	

IMPORTANT HEALTH QUESTION

Does your child have any past or present medical or dental conditions or disabilities? This may include heart issues, breathing problems, brain/seizure disorders, allergies (including drug allergies), diabetes, bleeding problems, communicable diseases or immune disorders etc. If Yes, explain below (attach additional pages as needed). IF NO, WRITE **NONE**.

List current medications	**List any dental concerns**

IF CHILD HAS MEDICAID

Enter child's Medicaid Recipient ID Number HERE: ☐☐☐☐☐☐☐☐☐☐☐

*Medicaid Program covers 100% of treatment

IF CHILD HAS PRIVATE INSURANCE	**Ins. Company (other than Medicaid)**	Ins. Phone
Group #	Employer Name	Co. Phone
Name of Insured Adult	**BIRTH DATE of Insured Adult**	
Member ID /Policy #		

IF CHILD HAS NO DENTAL INSURANCE ☐ **YES!** I would like someone to contact me with additional information

READ & SIGN BELOW

I give consent to Oral Health Impact Project, P.C. to perform the dental procedures and treatment, including examinations, x-rays, cleaning, preventative instructions, fluoride, sealants, filings and local anesthesia, which are deemed necessary for my child. If additional services are needed by my child, I must agree to those services before they are provided. I understand that the risks of dental treatment are uncommon but could occur. These risks include a possible allergic reaction or tissue irritation to local anesthetic, soreness, pain and swelling. This consent is valid for one year from the date signed.

SIGN AND DATE HERE _____ _____

DATE

QUESTIONS: OHIP 1-866-916-6447
Fax: 844-751-0258
Visit us at: ohip.us

ESPAÑOL AL REVERSO

For your privacy, please fold and secure.

ORAL HEALTH IMPACT PROJECT

ORAL HEALTH IMPACT PROJECT

¡EL DENTISTA VENDRÁ A SU ESCUELA!

Nuestra escuela se unió con
Oral Health Impact Project para ofrecer cuidado dental en la escuela SIN COSTO* para usted.

Cuidar de los dientes de su niño(a) es importante para mantenerlos sanos.

FÁCIL Y CONVENIENTE - Dentistas licenciados en el estado periódicamente revisará la boca y dientes de su hijo, igual proporcionará una limpieza y tratamiento de fluoruro. También proporcionará sellantes y rayos-x tal sean necesarios. Tratamiento adicional como rellenos podrían ser propocionados. El reporte incluye el tratamiento recibido y tratamiento requerido. ¡FIRME Y REGRESE A LA ESCUELA HOY!

LLENE POR FAVOR

Nombre Legal del Niño(a)		Fecha de Nacimiento	☐ Hombre ☐ Mujer
Dirección	Ciudad	Estado	Código Postal
Escuela	Maestro		Grado
Padre/Tutor Legal		Teléfono ( )	
Correo electrónico		Teléfono Alt. ( )	

PREGUNTA DE SALUD IMPORTANTE

¿Su hijo tiene alguna discapacidad o condiciones médicas o dentales en el pasado o presente? Puede incluir problemas del corazón, problemas de respiración, trastorno del cerebro/convulsiones, alergias (incluye alergia a medicamentos), diabetes, problemas de sangrado, enfermedades transmisibles o desorden inmunitario, etc. Si es así, por favor explique abajo (adjunte hojas adicionales si es necesario). Si No, escribe ninguno.

Anote los medicamentos que este tomando	**Anote cualquier problemas dental**

NIÑO(A) TIENE MEDICAID/

Llene los 11-digitos de Medicaid del Niño(a) AQUÍ: ☐☐☐☐☐☐☐☐☐☐☐

*Medicaid cubren 100% del tratamiento

NIÑO(A) TIENE SEGURO DENTAL PRIVADO	**Nombre de la Comp. de Seguro (aparte de Medicaid)**	Tel. del Seg
# Grupo	Empleador	Tel. del Empleador
Nombre del Adulto Asegurado	**FECHA DE NACIMIENTO DEL ADULTO ASEGURADO**	
# Póliza/ID		

NIÑO(A) NO TIENE SEGURO DENTAL ☐ **Sí!** Quisiera que alguien me contacte con información adicional.

LEA Y FIRME ABAJO

Solicito que el dentista realice una revisión dental a mi hijo(a) en la escuela la cual cubrirá el examen dental, limpieza, fluoruro, sellantes, y rayos-x como sean necesarios, así como otros trabajos dentales según la necesidad, incluyendo rellenos, extracciones de dientes de leche infectados, adormecimiento de la boca y dientes y otros procedimientos como se describe con más detalles en la parte posterior de esta página. Entiendo que OHIP proporcionará una copia del informe a la escuela para permitir que la escuela mantenga registros completos de salud para mi hijo. Este consentimiento si es válido por un año desde la fecha de firma. He leído la PREGUNTA IMPORTANTE DE SALUD al anterior y les informaré de cualquier cambio significante del salud de mi hijo(a) a 866-916-6447. He leído la ADVERTENCIA IMPORTANTE Y CONSENTIMIENTO EN LA PARTE POSTERIOR DE ESTA PAGINA, entiendo y estoy de acuerdo con sus términos.

FIRME Y FECHA AQUÍ _____ _____
FECHA

PREGUNTAS : OHIP 1-866-916-6447
Fax: 844-751-0258
Visit us at: ohip.us

Para su privacidad doble y asegure.

ORAL HEALTH IMPACT PROJECT

IMPORTANT NOTICE & CONSENT / AVISO IMPORTANTE Y CONSENTIMIENTO

I understand and authorize OHIP Pennsylvania, P.C and its affiliated dentists to provide the following services for the named child for whom I am the custodial parent or legal guardian: dental exam & oral hygiene instruction, teeth cleaning, fluoride treatment, x-rays & dental sealants. I give consent to Oral Health Impact Project, P.C. to perform the dental procedures and treatment, including examinations, x-rays, cleaning, preventative instructions, fluoride, sealants, filings and local anesthesia, which are deemed necessary for my child. If additional services are needed by my child, I must agree to those services before they are provided. I understand that the risks of dental treatment are uncommon but could occur. These risks include a possible allergic reaction or tissue irritation to local anesthetic, soreness, pain and swelling. This consent is valid for one year from the date signed. I understand that there are risks to dental treatment including swelling or pain that may occur from the injection of a local anesthetic or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number provided.) I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payer. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co pays. Treatment by the in-school dentist may affect future benefits that your child may receive under private insurance, Medicaid or CHIP. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. We may send you text messages about the school dental program. Message and/or data fees may be charged by your wireless service provider; to discontinue, reply "STOP" to any message received from us. You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form. I have received the Notice of Privacy Practices (NPP) attached to this form and consent to the release of my child's medical record information, including records obtained from other providers, and any HIV/AIDS, communicable disease, sexually transmitted disease, drug and alcohol, and anemia information. I authorize release of such information by Provider to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes. This signed consent authorizes my child's initial and future dental visits.

Entiendo y autorizo a OHIP Pennsylvania, P.C y a sus dentistas afiliados a proveer los siguientes servicios al niño(a) mencionado del cual soy el padre custodio o tutor legal: examen dental, limpieza de los dientes, tratamiento de fluoruro, rayos-x y sellantes. Solicito que el dentista realice una revisión dental a mi hijo(a) en la escuela la cual cubrirá el examen dental, limpieza, fluoruro, sellantes, y rayos-x como sean necesarios, así como otros trabajos dentales según la necesidad, incluyendo rellenos, extracciones de dientes de leche infectados, adormecimiento de la boca y dientes y otros procedimientos como se describe con más detalles en la parte posterior de esta página. Entiendo que OHIP proporcionará una copia del informe a la escuela para permitir que la escuela mantenga registros completos de salud para mi hijo. Este consentimiento si es válido por un año desde la fecha de firma. He leído la PREGUNTA IMPORTANTE DE SALUD al anterior y les informaré de cualquier cambio significante del salud de mi hijo(a) a 866-916-6447. He leído la ADVERTENCIA IMPORTANTE Y CONSENTIMIENTO EN LA PARTE POSTERIOR DE ESTA PAGINA, entiendo y estoy de acuerdo con sus términos.Autorizo y dirijo al Proveedor a facturar y recolectar pago de Medicaid, seguro privado o tercera persona. Si tengo seguro dental privado, seré facturado y acuerdo a pagar cualquier deducible y/o co-pago. El tratamiento realizado por el dentista escolar pudiera afectar los beneficios de su niño en en un futuro bajo su cobertura privada, Medicaid o CHIP. Al menos de que allá hecho algún arreglo previamente para atender y estoy ahí al momento de los servicios, el servicio será proveído sin mi presencia. En ocasiones podremos mandarle un texto sobre el programa dental escolar. Cobros de mensaje o/y de datos pueden ser aplicados por su proveedor de servicios inalámbrico; para descontinuar, responda "STOP" a cualquier mensaje que reciba de nosotros. Usted también acepta recibir transmisión pre grabada y/o auto llamadas telefonicas relacionadas con el programa dental escolar a los numeros telefonicos que usted proporciono en esta forma de consentimiento. He recibido el Aviso de Prácticas Privadas (NPP) adjuntas a este formulario y el consentimiento para la divulgación de la información y/o expediente médico de mi hijo(a), incluyendo los registros obtenidos de otros proveedores, y cualquier otra enfermedad como: VIH/SIDA, enfermedades contagiosas, enfermedades de transmisión sexual, drogas, alcohol, y anemia. Yo autorizo la divulgación de dicha información por parte de proveedores para cualquier pagador responsable y/o proveedor de servicios administrativos y de sus subcontratistas para el uso y divulgación de información relacionada con el tratamiento de mi hijo(a), pago para el mantenimiento y operación de cuidado dental. Esta forma de consentimiento firmada autoriza la visita dental inicial y visitas de seguimiento. Este permiso es válido desde la fecha de la firma hasta que mi estudiante ya no sea un estudiante de sistem a escolar, al menos que retire mi consentimiento por escrito. Puedo retirar mi consentimiento en cualquier momento por escrito.

MANTENGA PARA SUS ARCHIVOS

AVISO SOBRE PRACTICAS DE PRIVACIDAD

ESTE AVISO DESCRIBE CÓMO SU INFORMACIÓN MÉDICA PUEDE SER USADA Y DIVULGADA, Y COMO USTED PUEDE OBTENER ACCESO A DICHA INFORMACIÓN. POR FAVOR LEA ATENTAMENTE. MANTENGA PARA SUS ARCHIVOS

NUESTRO DEBER LEGAL

La privacidad de su información médica es importante para nosotros. Somos requeridos por leyes federales y estatales aplicables a mantener la privacidad de su información de salud. También somos requeridos a darle este Aviso acerca de nuestras prácticas de privacidad, nuestros deberes legales y sus derechos respecto a su información de salud. Debemos seguir las prácticas de privacidad descritas en este Aviso mientras se mantenga en efecto. Le notificaremos si es violada su información médica.

Reservamos el derecho de cambiar en cualquier momento los términos y prácticas de privacidad de este Aviso mientras tales cambios sean permitidos por las leyes aplicables. Reservamos el derecho de hacer cambios eficazmente en nuestras prácticas de privacidad y los nuevos términos de nuestro Aviso para toda la información médica que mantenemos, incluyendo información de salud creada o recibida antes de hacer los cambios. Antes de efectuar algún cambio significante a nuestras prácticas de privacidad, cambiaremos este Aviso y lo haremos disponible a su pedido.
Puede solicitar una copia de nuestro Aviso en cualquier momento. Para más información de nuestras prácticas de privacidad, o para copias adicionales de este Aviso, por favor póngase en contacto con nosotros usando la información que aparece al final de este Aviso.

USO Y DIVULGACION DE INFORMACION DE SALUD

Usamos y damos su información de salud para fines de tratamiento, facturación y operaciones de salud. Por ejemplo:
Tratamiento: Podemos usar o dar su información de salud a su médico, enfermera de la escuela o otro proveedor de salud que le esté proveyendo tratamiento.
Pagos: Podemos usar y dar su información de salud con fines de obtener pago por los servicios proveídos por nosotros a usted. Operaciones de Atención Médica: Podemos usar y dar su información médica con respecto a nuestras operaciones de negocio tales como revisión de competencia o calificación de los profesionales de salud y evaluación del rendimiento profesional y proveedor.
Su Autorización: Usos o divulgaciones no descritas en esta notificación pueden hacerse solo con su autorización por escrito. Además, debemos obtener su autorización por escrito para vender su información médica o para usar o dar su información para la comercialización de bienes o servicios a usted donde nos pagan para hacer la comunicación. Si usted nos da una autorización, usted puede anularla por escrito en cualquier momento. Su anulación no afectara cualquier uso o divulgación permitida por su autorización, mientras este en efecto. A menos que usted nos dé una autorización por escrito, no podemos usar o divulgar su información médica por cualquier motivo excepto los descritos en este Aviso.
A Su Familia y Amigos y Personas Involucradas en su Cuidado: Podemos dar su información médica a un familiar, amigo o otra persona involucrada en su cuidado en la medida necesaria para ayudar con su salud o con el pago de su atención médica. También podemos dar su información médica a organizaciones de ayuda de desastre para ayudar a localizar a individuos durante un desastre. También podemos utilizar o divulgar su información médica para notificar, o asistir en la notificación, de un miembro de la familia, un representante personal o una persona responsable de la localización de su cuidado, condición general o muerte. Si no desea que demos su información médica a miembros de la familia o otras personas en estas circunstancias, por favor notifique a nuestro oficial de HIPAA al 888-833-8441.
Requerido por La Ley: podemos utilizar o dar su información médica cuando estemos obligados a hacerlo por ley.
Seguridad Pública: Podremos dar información médica a oficiales la ley, para responder a una orden de allanamiento o una citación del gran jurado, o para ayudar a los oficiales de ley a identificar o localizar a un individuo, o para reporte de una muerte que pudo haber resultado por conducta criminal e informar una conducta criminal en nuestras instalaciones.
Abuso o Negligencia: Podemos dar su información médica a autoridades apropiadas si razonablemente creemos que usted es una víctima de abuso, negligencia o violencia doméstica o la posible víctima de otros delitos. Podemos dar su información de salud en la medida necesaria para evitar una amenaza grave para su salud o seguridad o la salud o la seguridad de los demás.
Seguridad Nacional: Podemos dar su información médica a las autoridades militares de las fuerzas armadas o de personal militar extranjero bajo ciertas circunstancias; a funcionarios federales de la ley de inteligencia legal, contrainteligencia y otras actividades de seguridad nacional y para proteger al Presidente; y a un oficial de la ley o institución correccional que tiene la tutela legal de un preso o paciente bajo ciertas circunstancias.
Recordatorios de citas: Podemos utilizar o dar su información médica para proporcionarle recordatorios de citas (por ejemplo, mensajes de voz, tarjetas postales, cartas, correos electrónicos o mensajes de texto).
Actividades de Supervisión de Salud: Podemos dar información médica a una agencia de supervisión de salud para actividades autorizadas por la ley. Estas actividades de supervisión por ejemplo incluyen, auditorías, investigaciones, inspecciones y encuesta de licencia. Estas actividades son necesarias para el gobierno para controlar el sistema de salud, el brote de enfermedades, programas de gobierno, el cumplimiento de las leyes de derechos civiles y para mejorar los resultados del paciente.
Demandas y Disputas: Podemos dar información médica sobre usted para responder a una orden judicial o administrativa. También
podemos dar información médica sobre usted en respuesta a una citación, solicitud de descubrimiento o otro proceso legal.
Otros Usos y Revelaciones: Podemos utilizar o dar su información médica para fines de investigación; a las organizaciones que manejan y monitorear la donación de órganos y trasplante, como sea permitido o requerido por la ley; para la compensación de trabajadores o programas similares a cumplir con las leyes relacionadas con la compensación de trabajadores o programas similares que proporcionan beneficios para lesiones relacionadas con el trabajo o la enfermedad; para actividades de salud pública tales como para prevenir o controlar enfermedades, lesiones o incapacidades; para reportar reacciones a medicamentos o problemas con productos; notificar a las personas de revocaciones de productos que pueden estar usando; para notificar a una persona que pudo haber sido expuesta a, o corre el riesgo de contraer o esparcir una enfermedad; a médicos forenses para identificar a una persona fallecida o determinar causa de muerte; o a directores de funerarias para llevar a cabo sus funciones.

DERECHOS DEL PACIENTE

Acceso: Usted tiene el derecho a ver o obtener copias de su información médica, con excepciones limitadas. Usted debe hacer una petición por escrito para obtener acceso a su información de salud y enviar su solicitud por fax al número al final de este Aviso.
Contabilidad de Divulgación: Usted tiene el derecho a recibir una lista de algunas revelaciones que hemos hecho nosotros o nuestros asociados de negocios de su información médica. Si usted ha solicitado esta información más de una vez en un período de 12 meses, podríamos cobrarle una cuota razonable, basado en los costos para responder a estas solicitudes adicionales.
Restricciones: Usted tiene el derecho a solicitar que restrinjamos el uso o divulgación de su información de salud. No estamos obligados a aceptar su solicitud, excepto cuando la divulgación sería a su plan de salud, usted (o alguien en su nombre que no sea su plan de salud) ha pagado total para el cuidado de su salud, la divulgación se refiere al pago o operaciones de cuidado de la salud, y la divulgación de lo contrario no es requerida por ley. Sin embargo, si estamos de acuerdo a la restricción, nos regiremos por ese acuerdo (excepto en caso de emergencia).
Comunicación Alternativa: Usted tiene el derecho de solicitar por escrito que nos comuniquemos con usted acerca de su información médica por medios alternativos o a lugares alternativos especificados en su petición.
Enmienda: Usted tiene el derecho de solicitar que nosotros enmendemos su información de salud. Su petición debe ser por escrito y debe explicar por qué se enmiende la información. Podemos negar su petición bajo ciertas circunstancias.
Aviso Electrónico: A su petición, usted tiene derecho a recibir esta notificación por escrito, si usted recibe este Aviso en nuestro sitio Web o por correo electrónico (e-mail).

PREGUNTAS Y QUEJAS

Si desea más información sobre nuestras prácticas de privacidad o tiene preguntas o inquietudes, por favor comuníquese con nosotros. Si usted está preocupado que podemos haber violado sus derechos de privacidad, puede quejarse con nosotros por medio la información que aparece al final de este Aviso. Usted también puede presentar una queja por escrito al Departamento de Salud y Servicios Humanos de los Estados Unidos. No tomaremos represalias de ninguna manera si usted decide presentar una queja con nosotros o con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Contacto oficial: HIPAA Officer
Teléfono:1-866-916-6447
Fax: 1-844-751-0258
email: HIPAA@OHIP.US
Fecha efectiva: August 1, 2016

IMPORTANT NOTICE & CONSENT / AVISO IMPORTANTE Y CONSENTIMIENTO

I understand and authorize OHIP Pennsylvania, P.C and its affiliated dentists to provide the following services for the named child for whom I am the custodial parent or legal guardian: dental exam & oral hygiene instruction, teeth cleaning, fluoride treatment, x-rays & dental sealants. I give consent to Oral Health Impact Project, P.C. to perform the dental procedures and treatment, including examinations, x-rays, cleaning, preventative instructions, fluoride, sealants, filings and local anesthesia, which are deemed necessary for my child. If additional services are needed by my child, I must agree to those services before they are provided. I understand that the risks of dental treatment are uncommon but could occur. These risks include a possible allergic reaction or tissue irritation to local anesthetic, soreness, pain and swelling. This consent is valid for one year from the date signed. I understand that there are risks to dental treatment including swelling or pain that may occur from the injection of a local anesthetic or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number provided.) I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payer. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co pays. Treatment by the in-school dentist may affect future benefits that your child may receive under private insurance, Medicaid or CHIP. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. We may send you text messages about the school dental program. Message and/or data fees may be charged by your wireless service provider; to discontinue, reply "STOP" to any message received from us. You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form. I have received the Notice of Privacy Practices (NPP) attached to this form and consent to the release of my child's medical record information, including records obtained from other providers, and any HIV/AIDS, communicable disease, sexually transmitted disease, drug and alcohol, and anemia information. I authorize release of such information by Provider to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes. This signed consent authorizes my child's initial and future dental visits.

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KEEP FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY. KEEP FOR YOU R RECORDS.

OUR LEGAL DUTY

The privacy of your medical information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We will notify you if your unsecured medical information is breached.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, school nurse, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our business operations such as reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this Notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you where we are paid to make the communication. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to help with your healthcare or with payment for your healthcare. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA Officer at 888-833-8441.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct, and to report criminal conduct on our premises.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your medical information to military authorities of Armed Forces or foreign military personnel under certain circumstances; to authorized federal officials for lawful intelligence, counterintelligence, or other national security activities, and to protect the president; and to a correctional institution or law enforcement official having lawful custody of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice-mail messages, postcards, letters, emails or text messages).

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process.

Other Uses and Disclosures: As permitted or required by law, we may use or disclose your medical information for research purposes; to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of some disclosures we or our business associates have made of your health information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, costbased fee for responding to these additional requests.

Restriction: You have the right to request that we restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan, you (or someone on your behalf other than your health plan) has paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: HIPAA Officer
Phone: 1-866-916-6447
Fax: 1-844-751-0258
email: HIPAA@OHIP.US
Effective Date: August 1, 2016

Your child's love of reading **begins with you.**

Sign up for Ready4K text messages to turn everyday moments into ones that build reading skills.

Ready4K is designed for families with children under five.

Ready4K

NAME:

CELL: ( )

E-MAIL (optional):

ZIP CODE:

CHILD'S BIRTH DATE: / /

LANGUAGE PREFERENCE (check one): ☐ ENGLISH ☐ SPANISH

SIGNATURE:

Send completed forms to Abby Thaker: thakera@freelibrary.org.

By signing up for Ready4K (the "Program") you hereby agree to (i) enroll in the Program, (ii) the ParentPowered PBC Terms of Use available at parentpowered.com/terms.html and Privacy Policy available at parentpowered.com/privacy.html, and (iii) receive approximately three Ready4K text messages per week from 70138. By signing up, you confirm that you want ParentPowered to send you information we think may be of interest to you, which involves ParentPowered using automated dialing technology to text you at the cell phone number you provided. While there is absolutely no cost for enrolling, data & message rates may apply. You can cancel your receipt of Ready4K text messages any time by texting **STOP** to 70138. For help with Ready4K text **HELP** to 70138 or email us at support@parentpowered.com.

For more ideas to help children become strong readers by 4th grade, visit **Readby4th.org**.

READ BY 4TH

Free Library of Philadelphia

Rev Effective July 1, 2020

PHLpreK Enrollment Confirmation

The family identified in this document has a child enrolled in the PHLpreK Program. This document will confirm the possible need for wrap-around care during the PHLpreK program year for the family who meets the subsidized child care eligibility requirements.

It is very important that the boxed area is **COMPLETELY FILLED OUT** by the PHLpreK provider. The hours must be defined as either AM or PM (e.g. 7:30AM – 3:30PM)

PHLpreK Child Care Program

Program Name:_____

Program Address: _____

City: **Philadelphia**, State: **PA** Zip Code:_____ Email:_____

Contact Person: _____ Phone: (____)-_____

When will your **PHLpreK** program begin for this year: **Begin Date**: ____/____/_____

When will your **PHLpreK** program end for this year: **End Date**: _____/_____/_____

Parent/Child Information:

Parent's Name: _____

Child's Name: _____Child's date of birth:_____

Parent's Address:_____ City **Philadelphia** Zip Code_____

PHLpreK Program Schedule (specific to the child listed above):

Date child enrolled with PHLpreK at your location: **Child started on**:_____/_____/_____

Enter the Child's daily PHLpreK schedule: **From**:_____ AM / PM **To**: _____ AM / PM

This form provides verification from the PHLpreK program to the ELRC agency that this child is enrolled in the above-named PHLpreK program. I affirm that all information I have given on this form is true, correct and complete to the best of my ability, knowledge and belief.

If the above-named child is withdrawn from my PHLpreK program before our program end date, I will notify the ELRC agency in writing by email confirmation at eligibility@caringpeoplealliance.org or by phone at 215-382-4762 immediately.

X_____ _____ _____

Provider Signature Title/Position Date

PARENT AUTHORIZATION TO RELEASE THIS INFORMATION

The parent: _____ _____authorizes and request the PHLpreK program to disclose to the ELRC agency all information contained in this form to verify my child's enrollment in PHLpreK and the Child Care Works Program.

X_____ _____ _____

Parent Signature Please Print Name Date

Rev Effective July 1, 2020

EARLY LEARNING RESOURCE CENTER
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

Early Learning Resource Center (ELRC)
Region 18
Serving Philadelphia County

Main Office
2361-2373 Welsh Road
Philadelphia, PA 19114

Satellite One
5548 Chestnut St
2nd Floor
Philadelphia, PA 19139

Satellite Two
1701 West Lehigh Ave
Suite 2102-2103
Philadelphia, PA 19132

Phone: 215-382-4762
Fax: 215-382-1199
Email: eligibility@caringpeoplealliance.org

Kindergarten Transition Plan

Date of Plan: _____ *(Data MUST be entered into Childware)*

Child's Name: _____Site/Classroom: _____

Teachers: _____ _____

Caregiver(s) or Guardian(s) Name(s): _____

Site Director: _____

Required Activities:

Use this form as a checklist to ensure all transition activities are completed. Document the date of the completed task in the "date completed" boxes. *Data entry notes should be entered only if the activity has been completed.

Who is responsible for the completion of this task?	Tasks/Responsibility	Target Date	Date Complete
Administrator or Site Director, with PHLpreK staff support. (collaborative effort)	**Childware Data Entry: (REQUIRED) *** Enter Kindergarten Transition Plan into Childware for children turning 5years old by **September 1st, 2021.**	**Before or by October 30, 2020**	
Teacher and Caregiver will discuss timeline together. *(collaborative effort)*	Initial discussion of the Kindergarten transition timeline with the caregiver or guardian.	By October 30, 2020	
Administrator or Site Director, with PHLpreK staff support. *(collaborative effort)*	Site must host a Kindergarten Transition Family Meeting at the PHLpreK site location.	By the end of February 2021	
Caregiver will attend site Kindergarten Meeting facilitated by site.	Attend a Kindergarten Transition Meeting.	By the end of February 2021	
Administrator or Site Director, with PHLpreK staff support. *(collaborative effort)*	**Childware Data Entry: (REQUIRED) *** Enter successful Kindergarten transition meeting attendance note into Childware.	**Before or by February 26th 2021**	
Teacher and Caregiver will discuss together	During the Kindergarten Transition meeting, recap the Kindergarten Registration timeline with the caregiver or guardian.	By the end of February 2021	
Administrator, Site Director, or Teacher *(collaborative effort)*	Confirm whether child has updated IEP or IHP *(if applicable)*	By the end of February 2021	
Teacher, Administrator, or Site Director, *(collaborative effort)*	Inform Families about Philadelphia School District Kindergarten Transition events (onsite/offsite) *(where applicable).*	By the end of February 2021	

Questions about how to use this tool? *Email PHLpreK for assistance PHLpreK@phmc.org*

Who is responsible for the completion of this task?	Tasks/Responsibility	Target Date	Date Complete
Caregiver will attend Kindergarten Transition Event with SDP	Attend a Philadelphia School District Kindergarten Transition Event for Families	Ongoing through May 2021	
Caregiver *(collaborative effort)* Administrator, Site Director, Teacher and or PHLpreK staff support Caregiver as needed	Caregiver will explore after school, summer care, options according to school/program timelines.	Ongoing	
Caregiver *(collaborative effort)* Site staff will follow up as needed to ensure timely submission of Kindergarten application.	Submit Kindergarten Application in person or through Online Portal	Ongoing through Kindergarten registration end date *(determined by School District of Philadelphia)* 2021	
Administrator, Site Director, Teacher, PHLpreK Staff *(collaborative effort)*	Ensure the family has all information necessary for Kindergarten registration and transition.	Ongoing through May 2021	
Caregiver *(collaborative effort)* Program staff will follow up & support family as needed.	Acquire Kindergarten registration materials and complete Kindergarten registration according to school/district timelines	Ongoing	
Caregiver, Teacher, Administrator, and or Site Director *(collaborative effort)* Site Staff will attend IEP/IHP meeting with caregivers. *(if applicable)*	Caregiver will attend IEP/IHP transition meeting with new school. *(if applicable)*	Ongoing	
Administrator, Site Director, and or Teacher. *(collaborative effort)*	**Childware Data Entry: (REQUIRED) *** Confirm that the Kindergarten registration process is completed and document where the child will be attending.	**Before or by June 4, 2021**	

Notes:

Date Complete plan entered into child file: _____

Person(s) completing documentation: _____

A copy of this transition plan MUST be placed in the child's file and will be audited during PHLpreK on-site monitoring visits.