School Readiness Program Match

2024-2025 School Readiness Program Match Parent Application

Dear Parent,

School Readiness Program Match is a 50/50 partnership between your employer and the Early Learning Coalition to provide employees with childcare services. **The Early Leaning Coalition pays 50% of the childcare cost and the employer pays the remainder after the parent fee is determined.**

Parents must apply using the attached application.
The School Readiness Program Match Parent Application is available on our website at **https://www.elcmdm.org/parents/our-services/school-readiness-program-match.**

***The parent submits the completed School Readiness Program Match application, including supporting documentation, to one of the ELC's Service Centers listed below for processing. Applications cannot be emailed, mailed or uploaded to the DEL Provider Portal.**

Miami-Dade County:

South Service Center: The Centre at Cutler Bay Condominium, 18951 SW 106 Ave., Unit B-208, Miami 33157

Central Service Center: United Way Campus, 3250 SW 3rd Avenue, Miami 33129

North Service Center: 15100 NW 67th Avenue, Suite 207, Miami Lakes 33014

Miami-Dade County Service Center Hours:
Monday to Wednesday 9:00 am to 5:00 pm
Thursday: 10:00 am to 6:00 pm
Friday: Not open to the public
Saturday: 10:00 am to 1:00 pm (Last Saturday of each month)

Miami-Dade Satellite Locations: Various hours and days of operation

Hialeah Satellite Center: CITRUS Health Network
551 West 51st Place, 2nd Floor, Hialeah, 33012
Hours of Operation: Tuesday and Thursday 9:00 am to 5:00 pm

Sant La South Hub
900 NE 23rd Street, Homestead, 33033
Hours of Operation: Monday and Wednesday 9:00 am to 5:00 pm

Community Medical Group
1490 NW 27th Avenue, Miami, 33125
Hours of Operation: Tuesday and Thursday 9:00 am to 5:00 pm

Community Medical Group – Westchester
1607 SW 107th Avenue, Miami, 33165
Hours of Operation: Monday and Wednesday 8:00 am to 5:00 pm

Sant La North Hub
13450 West Dixie Hwy, North Miami, 33161
Hours of Operation: Wednesday 9:00 am to 5:00 pm

Monroe County:

Upper Keys Service Center: Pink Plaza, 103400 Overseas Highway, Suite 112, Key Largo, 33037
Hours of Operation:
Monday to Thursday 9:00 am to 5:00 pm
Friday: By appointment

Middle Keys Service Center: Martin Luther Chapel, 325 122nd Street, Marathon, 33050
Hours of Operation:
Wednesday 9:00 am to 5:00 pm
Call for an appointment 305-296-5557 x 2368

Lower Keys Service Center: Professional Plaza, 1111 12 Street, Suite 206, Key West, 33040
Hours of Operation:
Monday to Thursday 9:00 am to 5:00 pm
Friday: By appointment

Thank you for your cooperation.

SRPM Pre-Screening Form

2024-2025

FACILITY INFORMATION			
Name of Facility		Provider ID:	Provider ID Extension
Address			
City		Zip	
Phone Number		Fax Number	
E-mail		Employer Identification Number (EIN):	

FAMILY INFORMATION			
How may we contact the family? ☐Home phone ☐Work phone ☐Cell phone			
What time is usually best to call? ☐Morning ☐Afternoon ☐Evening			
Marital Status: ☐Married ☐Single ☐Single living with companion			
Total number of adults in your household: _____ Total family size: _____			
Do all adults in the household work at least 20 hours a week? ☐Yes ☐No			
Employee's Name:		Last 4 digits of SS#	
Address:		City	Zip Code
Phone		Fax	

CHILD(REN) INFORMATION			
Name of Child (LAST, FIRST, MI)	**Last 4 digits of SSN**	**Date of Birth**	**Provider name and care needed (FT or PT)**
			☐FT ☐PT
			☐FT ☐PT
			☐FT ☐PT
			☐FT ☐PT
			☐FT ☐PT

SRPM Pre-Screening Form

2024-2025

AUTHORIZED BUSINESS REPRESENTATIVE INFORMATION			
Name			
Signature			
Title		Date	
Phone		Fax	

Bring the completed package and supporting documentation to your local Early Learning Coalition Service Center. Please find ELCMDM Locations at https://www.elcmdm.org/contact-us/locations.

Early Learning Coalition of Miami-Dade/Monroe

SSN# (Last Four) (If Applicable):_____

Date: _____

Name: _____

Telephone #:_____

Given to: _____

☐ *I hereby certify that I've obtained a copy of the Consumer Statement*

Parent's signature: _____

Date: _____

Parent's provider choice: Please list child care provider's name, address and phone number below:

Provider's name _____

Provider's address _____

Provider's phone number _____

☐ **N/A**

Child Care Application
Aplicación para Cuidado Infantil

Parent/Guardian Information *Información del Padre/Guardián*

Last Name *Apellido*	First Name *Nombre*	MI (print) *Inicial*	Social Security # (last 4 digits) *Número del Seguro Social (los últimos 4 dígitos)*	DOB *Fecha de Nacimiento*	Sex *Sexo*	Race *Raza*

Spouse or other Parent (if applicable) Last name *Cónyugue u otro Padre (si aplica) Apellido*	First Name *Nombre*	MI (print) *Inicial*	Social Security # (last 4 digits) *Número del Seguro Social (los últimos 4 dígitos)*	DOB *Fecha de Nacimiento*	Sex *Sexo*	Race *Raza*

Address *Dirección*	City *Ciudad*	State *Estado*	Zip *Zona Postal*	Other Phone No *Teléfono de casa*	Home Phone No *Otro Teléfono*

Client's legal marital status | *Estado civil legal*

❑ Single *Soltero(a)* ❑ Married *Casado(a)* ❑ Divorce *Divorciado(a)* ❑ Widowed *Viudo(a)* ❑ Separated *Separado(a)*

Child(ren) authorized to receive care | *Niños(as) autorizadas a recibir servicios*

Name *Nombre*	Social Security # *Número del Seguro Social*	Birth Date *Fecha de Nacimiento*	Race *Raza*	Sex *Sexo*	Relationship to Client *Relación al cliente*

Provider Information | *Información de Proveedores*

Please list the name and address of the Early Care and Education provider where you would like to enroll your child(ren). If you need help choosing a quality child care provider, need a list of child care providers in your area or have other questions or concerns please contact Child Care Resource & Referral at: 305-646-7220

Por favor, indique el nombre y la dirección del proveedor de cuidado y educación infantil donde desea inscribir a sus hijos. Si necesita ayuda para elegir un proveedor de calidad, si necesita un listado de proveedores en su área, necesitará una lista de proveedores su área o si tiene otras preguntas o inquietudes, comuníquese con Child Care Resource & Referral al: 305-646-7220.

Name *Nombre*	Address *Dirección*	Telephone Number *Número telefónico*

Household Information | *Información del Hogar*

How many people live in your house (boyfriend, child over 18, etc.) | *Número de personas en su hogar (novio/a, hijo/a mayor de 18 años, etc)*

Adults | *Adultos* ___ Children | *Niños*___ Describe relationship | *Describa la relación* _____

Lists others living in household *Otros que habitan en su hogar*	Social Security # (last 4 digits) *Número del Seguro Social (los últimos 4 dígitos)*	Birth Date *Fecha de Nacimiento*	Race *Raza*	Sex *Sexo*	Relationship *Relación*	Income *Ingreso*

I hereby certify that the information provided above is correct. I understand that if I give false information my case may be referred to the Florida Department of Financial Services, Public Assistance Fraud for action.

Certifico que la información provista es correcta. Entiendo que si proveo información falsa, mi caso podrá ser referido al Departamento de Servicios Financieros, Fraude de Asistencia Publica, para acción.

Applicant Signature Firma del Cliente X _____ **Date** | Fecha _____

Office of Early Learning

INCOME WORKSHEET for Eligibility and Parent Copayments

SECTION I. EARNED INCOME

Complete the following information about each adult family member in the household who is employed or participating in education:

Check One: **Single Parent Household** **Two-Parent Household**

Parent(s) with whom the child resides (include parents by marriage or adoption)

Name of Person Who Works	Name, Address and Telephone Number of Employer(s)	Source of Earned Income	Gross Earned Income (before taxes)		Weekly Work Schedule		
			Frequency	Amount	Day of Week	From	To
Parent 1 :			☐ Weekly	$	Monday		
			☐ Bi-weekly*	$	Tuesday		
			☐ Semi-monthly*	$	Wednesday		
			☐ Monthly	$	Thursday		
			☐ Annual	$	Friday		
					Saturday		
					Sunday		
		Total Gross Annual Earned Income:		$	**Total Hours Worked Per Week:**		
Education	**Name, Address and Telephone Number of School:**			Semester Quarter Other	**Total Classroom/ Lab Hours Per Week:**		
Parent 2:			☐ Weekly	$	Monday		
			☐ Bi-weekly*	$	Tuesday		
			☐ Semi-monthly*	$	Wednesday		
			☐ Monthly	$	Thursday		
			☐ Annual	$	Friday		
					Saturday		
					Sunday		
		Total Gross Annual Earned Income:		$	**Total Hours Worked Per Week:**		
Education	**Name, Address and Telephone Number of School:**			Semester Quarter Other	**Total Classroom/ Lab Hours Per Week:**		
Additional adult family members in the home who are employed (include children over 18 who are not enrolled as full-time students in secondary schools or their equivalent and related adults who are supported by the family)							
Additional Household Member 1:			☐ Weekly	$	Monday		
			☐ Bi-weekly*	$	Tuesday		
			☐ Semi-monthly*	$	Wednesday		
			☐ Monthly	$	Thursday		
			☐ Annual	$	Friday		
					Saturday		
					Sunday		
		Total Gross Annual Earned Income:		$	**Total Hours Worked Per Week:**		
Additional Household Member 2:			☐ Weekly	$	Monday		
			☐ Bi-weekly*	$	Tuesday		
			☐ Semi-monthly*	$	Wednesday		
			☐ Monthly	$	Thursday		
			☐ Annual	$	Friday		
					Saturday		
					Sunday		
		Total Gross Annual Earned Income:		$	**Total Hours Worked Per Week:**		

***Biweekly means paid every other week; Semi-monthly means paid twice per month**

SECTION II. DEDUCTIONS

If any family member makes any of the following type of payments, check the type of payment made. Enter the case or account number, the amount paid, the name of the family member making the payment, and the date of the last payment. These payment types are to be deducted or excluded from total family income.

	Authorized Deductions	Case/Account Number	Monthly Amount	Annual Amount	Name of Family Member Making Payment	Date of Last Payment
	Child support payments made pursuant to a court order		$	$		
	Alimony paid pursuant to a court order		$	$		
			$		**Total Annual Authorized Deductions**	

SECTION III. UNEARNED INCOME

If any family member receives any of the following type of unearned income (or benefits), check the type of benefits received. Enter the case or account number, the amount received, and the name of the family member receiving the payment.

	Unearned Income Type	Case/Account Number	Monthly Amount	Annual Amount	Name of Family Member Receiving Payment
	Food Stamps benefits and Family Subsistence Supplemental Allowance (FSSA)**		Exempt $	Exempt $	
	Housing assistance, including Military Housing Assistance		Exempt $	Exempt $	
	TANF cash assistance		$	$	
	Dividends/Interest		$	$	
	Social Security Disability income		$	$	
	Supplemental Security Income (SSI)		$	$	
	Veteran's benefits		$	$	
	Retirement benefits-including Social Security, railroad retirement or other types of pensions not previously identified		$	$	
	Child Support received (list)		$	$	
			$	$	
			$	$	
	Alimony received		$	$	
	Worker's Compensation benefits		$	$	
	Unemployment Compensation benefits		$	$	
	Income/money received from non-family members residing in the household		$	$	
	Other unearned income (list):		$	$	
			$	$	
			$		**Total Annual Unearned Income**

****Do not include in the calculation of Total Annual Unearned Income. For federal reporting purposes only.**

Total Annual Gross Income (Earned Income + Unearned Income – Deductions)	**Household Size** (Include parent(s), children, and related adults in the home)	**Required Family Contribution/Parent Copayment**
$		**$**

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.

Signature of Parent/Guardian	Date	Signature of Eligibility Determiner	Date

Child support statement

Declaración de Manutención

Select one of the statements listed below based on support for each child in the household. **You need to provide proof of the amount of child support for each child counted in the household.**

Seleccione la declaración que describe la manutención de cada niño en su familia: ***Usted tiene que presentar prueba del monto de manutención por cada niño que es parte del hogar***

❑ I hereby certify that **I DO** receive child support for the following children: Proof of child support must be provided the last 6 weeks – Written statement from absent parent, stubs, document from Clerk of Court, or print out from *www.myfloridacounty.com*

Child's Name	Absent Parent's Name/Court Case #

❑ *Yo certifico que recibo manutención para el siguiente/s niño/os: Prueba de pago de manutención por las últimas seis semanas- declaración del padre ausente, copias de cheques/ money orders, documentos de la corte o impreso del historial de pagos de www.myfloridacounty.com*

Nombre del Niño/s	*Padre Ausente/# de caso judicial*

❑ I hereby certify that **I DO NOT** receive child support for the following children: **You need to list every child counted in the household.**

Child's Name	Absent Parent's Name

❑ Yo certifico que no recibo manutención por el siguiente/s niño/s: **Liste todos los niños que son parte del hogar.**

Nombre del Niño/s	Padre Ausente

❑ I agree to notify the Early Learning Coalition within ten (10) days if my situation changes in any way.

❑ Yo estoy de acuerdo en notificar al Early Learning Coalition en diez (10) días si la situación cambia en alguna forma.

The information provided on this form is true and complete to the best of my knowledge. I fully understand that any omissions, falsifications or misrepresentations may disqualify my child(ren) from receiving child care and that I may be liable for prosecution under the full strength of law plus repayment of ineligible child care services.

La información proporcionada en este formulario es verdadera y completa a lo mejor de mi conocimiento. Entiendo completamente que cualquier omisión, falsedades o mala representación pueden descalificar a mi(s) hijo(s) de recibir cuidado infantil y que puedo ser responsable de enjuiciamiento en virtud de toda la fuerza de la ley y reembolso de los pago de los servicios de cuidado no elegibles.

✗ **Client's Signature** **Date**

Firma del Cliente *Fecha*

Terms and Conditions for Application

Condiciones para la Aplicación

Your Choice of Child Care

You may choose from legally operating, child care arrangements and providers including: licensed centers, licensed homes, registered homes, faith-based care, school based pro- grams, in-home care, relative care or other informal arrangement providers with an executed Provider Agreement with the Early Learning Coalition of Miami-Dade/Monroe. You are guaranteed the right of "parental choice" in selecting a child care provider. "For children at risk of abuse or neglect, informal childcare may only be authorized by exception when no licensed child care homes or facilities are available within close proximity to work or home. (CCDF 3.1.4)" Your child will not be placed in any child care arrangement without your approval. The Florida Office of Early Learning and the Early Learning Coalition have the right to initiate and/or receive data either through direct contact or an automated data exchange process to establish the validity of household information provided by the applicant/recipient to receive program benefits. This will include but not necessarily be limited to: social security benefits, birth dates, immunization status and/or all sources of potential and reported earned and unearned income sources. (Employment records, unemployment benefits, TANF, Child Support, etc.)

Access to children in care

Your child care provider must allow you to visit your child at any time while they are in care.

You may lose your child care if you:

1. **Fail to comply with your Career Source Worker/DCF requirements, or**
2. **Fail to provide documents or information required by the family support specialist, or**
3. **Fail to pay your "parent fee" to the child care provider or establish a repayment plan for the outstanding co-payment obligation, or**
4. **Knowingly provide false information during the application or redetermination process, or**
5. **Fail to notify the Early Learning Coalition (ELC) of any changes in your participation, employment, or family circumstanc es including change of address and changes in family composition within 10 calendar days, or**
6. **Fail to complete the re-determination process prior to the last authorized day ofservices.**

Su Elección de Cuidado Infantil

Usted puede escoger cualquier proveedor de cuidado infantil que opere legalmente y tenga una licencia, incluyendo: centros con licencia, hogares con licencia, hogares registrados, instituciones religiosas, programas escolares, cuidado en la casa, cuidado de parientes, u otro método informal de cuidado que hayan firmado un "Acuerdo de Proveedor" con el Early Learning Coalition of Miami-Dade/Monroe. Se le garantiza el derecho de "Elección de los Padres" para su selección de proveedor de servicios. "Para niños en riesgo de abuso o negligencia, el cuidado informal de niños sólo será autorizado como excepción cuando no hayan hogares o instalaciones de cuidado infantil con licencias disponibles cerca del trabajo o el hogar. (CCDF 3.1.4)" Su hijo/a no será inscrito en ningún programa sin su aprobación. La oficina de Educación Temprana De la Florida y la Coalición De Educación Temprana (ELC) tiene el derecho de iniciar o recibir información a través de contacto directo o un proceso automatizado de intercambio de datos para establecer la validez de la información del hogar proporcionada por solicitante/beneficiario para recibir los beneficios del programa. Esto incluirá pero no se limita a: beneficios del seguro social, fecha de nacimiento, estatus de inmunización, y/o fuentes de ingresos o posibles ingresos devengados o no. Registros de empleo, prestaciones por desempleo, asistencia temporal para familias necesitadas –TANF, manutención de menores, etc.)

Acceso a sus Hijos durante el Cuidado Infantil

El proveedor deberá permitirle visitar a su hijo/a en cualquier momento que usted desee mientras estén bajo este cuidado.

Podría perder servicios de cuidado infantil si:

1. ***No cumple con los requisitos del programa de empleo Career Source/Departamento de Niños y Familias, o***
2. ***No provee los documentos o información requerida por su especialista de servicios a la familia, o***
3. ***Falta en el cumplimiento del pago de su cuota al proveedor o arreglo de plan de pago de la deuda pendiente, o***
4. ***Si provee conscientemente información falsa durante el proceso de aplicación o re-determinación, o***
5. ***Si no notifica a la Coalición de Educación Temprana (ELC) de cualquier cambio en su participación, empleo, o circunstancias familiares incluyendo cambios de dirección, teléfono, y/o cambios en la composición familiar en 10 días del cambio, o.***
6. ***S i n o completa el proceso de re-determinación antes de la fecha de vencimiento de sus servicios.***

Parent/Guardian Statement

I have read and understand the above information. I certify that the information given in my application is true and com- plete to the best of my knowledge. I understand that if I pro- vide false information, I may be liable for prosecution under state law and child care services will be terminated.

For all children not yet enrolled in school, the subsidized child care program will provide developmental screening. I consent to this screening with the understanding that I will receive the results of that screening and will be informed of any recommendations.

I give consent to the Department of Children and Families and/or the Florida Department of Financial Services, Public Assistance Fraud to request all information relating to my eligibility and to make inquiry into all statements or information given in the application. I understand that if I give false information, sign inaccurate attendance documents or fail to report changes in my circumstances, my case may be referred to the Florida Department of Financial Services, Public Assistance Fraud Division, for action.

I understand that I may not be discriminated against based on race, national origin, ethnic background, sex, religious affiliation or disability.

I understand that I may request a case review by the Early Learning Coalition of Miami-Dade/ Monroe for any decision that is made to impact my child care services and I have the right to file a formal grievance/appeal regarding decisions made on my case

Declaración de los Padres

He leído y entendido la información proporcionada. Certifico que la información presentada en la aplicación es verdadera y está completa. Entiendo que si doy información falsa, podría ser sometido a juicio bajo las leyes estatales y el servicio de cuidado infantil será terminado.

Para todos los niños que aún no estén inscritos en la escuela, el programa subsidiado de cuidado infantil proveerá evaluaciones del desarrollo infantil. Doy mi aprobación para estas evaluaciones con el entendimiento que recibiré los resultados y seré informado de cualquier recomendación.

Doy mi consentimiento al Departamento de Niños y Familias y/o al Departamento de Servicios Financieros, División de Fraude de Asistencia Pública para que solicite toda información relacionada con mi elegibilidad, que investigue todas las declaraciones y toda la información presentada en la aplicación. Entiendo que si proveo información falsa, firmo hojas de asistencia erradas, o fallo en reportar cambios en las condiciones familiares, mi caso podrá ser referido al Departamento de Servicios Financieros, División de Fraude de Asistencia Pública.

Entiendo que no puedo ser discriminado basado en raza, origen, nacionalidad, sexo, religión o incapacidad.

Entiendo que puedo solicitar una revisión de mi caso al Early Learning Coaliton de Miami-Dade/Monroe con respecto a cualquier decisión que pueda afectar mis servicios de cuidado infantil .y tengo el derecho de presentar una apelacion formal con respecto a las decisiones que afectan mi caso.

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X _____ _____

Parent or Legal Guardian (Signature) | *Padres o Guardianes (Firma)* **Date | *Fecha***

X _____ _____

Secondary Parent (Signature) | *Padres Secundario (Firma)* **Date | *Fecha***

REMINDER! If you have not completed a renewal before your care end date, YOU are responsible for contacting your child care provider or the Early Learning Coalition.

¡RECUERDE! Si usted no completa su renovación antes de la fecha de vencimiento de su caso, es su responsabilidad contactar a su proveedor de servicios o al Early Learning Coalition.

School Readiness Transfers

Parent Responsibility

- A parent may not transfer his or her child to another school readiness program provider until the parent has submitted documentation from the current school readiness program provider to the early learning coalition stating that the parent has satisfactorily fulfilled the co-payment obligation related to school readiness program or established a repayment plan for the outstanding co-payment obligation. All transfers, except at-risk protective services clients, must be approved by the coalition. Provider transfer for at-risk protective services client must be approved by the Child Welfare Program Office of the Department of Children and Families and done in accordance with rule 65C-13.030(2)(d), FAC for children in licensed out-of-home foster care.
- If a parent of an at-risk child defined ins.1002.81 (1), F.S., is unable to satisfactorily fulfill the co- payment obligation prior to transfer, the provider shall attempt to arrange a repayment plan with the at-risk child's parent. If the provider is unable to arrange a payment plan with the at-risk child's parent, the provider shall document the repayment attempt and submit to the coalition. The coalition shall report the parent's intent to transfer child care providers to the Child 'Welfare Program Office of the Department of Children and Families or the community-based agency.
- If the family has a change in residence within the state to a different coalition service area the school readiness funding shall transfer to the coalition service area that the family relocate to. Funding shall reflect the remaining balance of 12- month eligibility. The parent co-payment may not be increased due to a transfer of services outside of the coalition service area.

Responsabilidad de los padres

- Un padre no puede transferir a su hijo a otro proveedor del programa de preparación escolar hasta que el padre haya enviado la documentación del proveedor actual del programa de preparación escolar a la coalición de aprendizaje temprana que indique que el padre ha cumplido satisfactoriamente la obligación de su copago o haya establecido un plan de pago con el proveedor para cubrir la deuda pendiente. Todas las transferencias, excepto los clientes que reciben servicios de protección, deben ser aprobadas por la coalición. Las transferencias de los clientes de servicios de protección deben ser aprobadas por la Oficina del Programa de Bienestar Infantil del Departamento de Niños y Familias y debe llevarse a cabo de acuerdo con la regla 65C-13.030 (2) (d), FAC para niños que residen fuera de sus hogares en residencias con licencia de cuidado de crianza en el hogar.
- Si un padre de un niño en riesgo basado en el artículo 1002.81 (1), FS, no puede cumplir satisfactoriamente con la obligación de su copago antes de la transferencia, el proveedor debe intentar crear un plan de pago con el padre del niño en riesgo. Si el proveedor no puede crear un plan de pago con el padre del niño en riesgo, el proveedor deberá documentar el intento de reembolso y presentar la prueba a la coalición. La coalición informará la intención de los padres de transferir proveedores a la Oficina del Programa de Bienestar Infantil del Departamento de Niños y Familias o la agencia comunitaria.
- Si la familia tiene un cambio de residencia dentro del estado a un área de servicio de otra coalición, los fondos de preparación escolar se transferirán al área de servicio de la coalición a la que se reubico la familia. El servicio reflejará el tiempo restante de la elegibilidad de 12 meses. El copago de los padres no puede aumentar debido a una transferencia de servicios fuera del área de servicio de la coalición.

_____ _____

Parent Signature **Date**

Firma del padre principal **Fecha**

Updated 8/8/2018

Sharing the Cost

In accordance with the rules of the State of Florida, the Early Learning Coalition will pay your child care provider a monthly amount. You are responsible for paying the provider your assessed fees. Also, if your provider's rate exceeds the State's approved amount, it will be your responsibility to pay this amount and any other added expenses.

EXAMPLE:

The Provider's weekly care rate	$100.00
The State's approved rate	80.00
The difference between the provider's rate and the State's approved rate	$ 20.00

Your ELC assessed weekly fee, based on your family size and income documentation, is $24.00 which is deducted from the State's approved weekly rate of $80.00.

You are responsible for paying the provider $44.00 per week ($24.00 assessed fee plus the $20.00 difference).

Please understand that your eligibility for child care is only authorized for the specific date and time reflected on your rights and responsibilities for service form. Continued care requires that your eligibility status be redetermined on a periodic basis.

Please be aware, if any changes in your income, household size, employment, and school program or child care arrangements occur, it is your responsibility to report this information to your Eligibility Counselor within ten (10) calendar days.

De acuerdo con las regulaciones del estado de la Florida, Early Learning Coalition pagara a su centro infantil un monto mensual. Es su responsabilidad pagarle a su centro infantil su tarifa correspondiente. Tenga presente, que si la tarifa de su centro infantil excede el monto aprobado por el estado, es su responsabilidad pagar el exceso y cualquier otro gasto adicional.

EJEMPLO:

Tarifa semanal del proveedor	$100.00
Tarifa aprobada por el estado	80.00
Diferencia entre la tarifa del proveedor y la tarifa aprobada por el estado	$ 20.00

Basado en sus ingresos y en el tamaño de su familia, ELC calcula su tarifa en $ 24.00, esta tarifa se deducirá de su tarifa semanal aprobada por el estado.

Por lo tanto, es su responsabilidad pagar al proveedor $ 44.00 semanales ($ 24.00 de la tarifa establecida y $ 20.00 de la diferencia)

Por favor comprenda que la elegibilidad de su niño es autorizada solamente por el período específico reflejado en su forma de derechos y responsabilidades. Para continuar con sus servicios, su estado de elegibilidad debe ser redeterminado periódicamente.

Tenga presente que si su familia experimenta algún cambio en sus ingresos, tamaño de la familia, empleo, programa educacional o arreglos para el cuidado infantil, es su responsabilidad reportar esa información a su consejero de elegibilidad dentro de 10 días consecutivos.

Parent Signature **Date**

Firma del padre principal **Fecha**

Client Address Change Request

Solicitud de Cambio de Dirección del Cliente

If you changed your address, complete this form and include a copy of one item from the following list:
Si ha cambiado su dirección, complete este formulario e incluye copia de uno de los documentos enumerados a continuación:

- ☐ Drivers license (current) / *Licencia de conducir (vigente)*
- ☐ Deed, mortgage / *Título de propiedad, hipoteca*
- ☐ Voters Registration Card / *Tarjeta de registro de votante*
- ☐ Florida vehicle Registration or title / *Registro o título de Vehículo de la Florida*
- ☐ Car Payment booklet / *Colillas de pagos de su vehículo*
- ☐ Utility bills: not more than 2 months old / *Facturas recientes de las compañía de servicios públicos no más de 2 meses*
- ☐ Telephone Bill: not more than 2 months old / *Factura de Teléfono más reciente no más de dos meses*
- ☐ Property tax bill / *Impuestos sobre la propiedad.*
- Lease / *Contrato de alquiler.*

Your Information | *Su Información*

If you fail to provide documented proof of new address, your address cannot be changed.
Si usted no proporciona la prueba documentada de su nueva dirección, ésta no puede ser cambiada.

Last Name | *Apellido*

First Name | *Nombre*

Date of Birth | *Fecha de Nacimiento*

Social Security No. | *Seguro Social*

OLD Address | *Dirección Antigua*

Street | *Calle*

City | *Cuidad*

State | *Estado*

Zip | *Código Postal*

NEW Address | *Nueva Dirección*

Street | *Calle*

City | *Cuidad*

State | *Estado*

Zip | *Código Postal*

Home telephone | *Teléfono de casa*

Best number to reach you | *El mejor Número telefónico para comunicarse con UD*

✗ _____ _____

Primary Parent/Guardian Signature ❙ *Firma del Padre (Madre)/Guardián Primario(a)* **Date ❙** *Fecha*

The Early Learning Coalition of Miami-Dade/Monroe is one of the three grantee awarded the Early Head Start Childcare Partnership program which you may also qualify to receive. Early Head Start services children 0-3 years old at top quality early child care centers. With Early Head Start you will enjoy receiving health services at with Jackson Health Systems, a personal family advocate, and quality child care. If you would like to hear more about the program please fill out the survey below.

*Is your child 0-3 years old? Yes____ No_____

*What is your child's date of birth? (MM/DD/YYYY)

a._____ b._____ c._____

*What is your zip code?

[ ] 33030 [ ] 33054 [ ] 33111 [ ] 33128 [ ] 33135 [ ] 33142 [ ] 33151 [ ] 33034 [ ] 33090 [ ] 33127 [ ] 33130

[ ] 33136 [ ] 33150 [ ] Other _____

Is your child currently receiving school readiness? Yes _____ No____

If not, why? _____

*Does your child have a diagnosed disability? Yes _____ No _____

*If so, does your child have an Individual Family Service Plan? Yes ____ No ____

Name: _____

Phone number: _____

Email: _____