Ohio Department of Job and Family Services Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBLITY SCREENING TOOL

Tell us about you (the applicant)								
First Name			Last Na	ame				
Address						Today's	Date	
City	State Cour			County Zip Code				
Phone Number ()	Additional Phone	dditional Phone Number E-n		I Address				
Tell us about the people in	your home							5058
Name (First, Middle, Last)	Relationship to You (spouse, son, friend, etc.)	Race		Hispanic or Latino Yor N	Spoken Language	Date of Birth	Gender M or F	U.S. Citizen Y or N
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander						
		African American Alaska Native/American Indian Asian Caucasian Hawaiian/Pacific Islander						
		African American Alaska Native/American Indian Asian Caucasian Hawaiian/Pacific Islander						
		☐ African Ame ☐ Alaska Nativ Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pa	e/American					
		☐ African Ame ☐ Alaska Nativ Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pa	e/American					

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Child 1	Provider Name and Address	What hours/days do you need services? (i.e. child care or preschool) Check all that apply		
Name	41147144790	Sun Mon Tues Wed Thurs Fri Sat		
		☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends		
Child's Mother's Maiden Name		What is the child's home school district?		
Child's City of Birth				
Special Needs				
"Special needs child care" or more chronic health cor including social, emotiona may include on a regular to function or development.	าดเนอกร or does not meet age I, cognitive, communicative, r	on this definition? o a child who is less than eighteen years of age and either has one appropriate expectations in one or more areas of development, perceptual, motor, physical, and behavioral development and that ons, modifications, or adjustments needed to assist in the child's		
☐ Yes ☐ No				
Child 2	Provider Name and Address	What hours/days do you need services? (child care or preschool) Check all that apply		
Child 2 Name		What hours/days do you need services? (child care or preschool) Check all that apply Sun Mon Tues Wed Thurs Fri Sat		
		Check all that apply		
		Check all that apply Sun Mon Tues Wed Thurs Fri Sat Mornings Afternoons		
		Check all that apply Sun Mon Tues Wed Thurs Fri Sat Mornings Afternoons Evenings		
Name Child's Mother's Maiden		Check all that apply Sun Mon Tues Wed Thurs Fri Sat Mornings Afternoons Evenings Weekends		
Name Child's Mother's Maiden Name		Check all that apply Sun Mon Tues Wed Thurs Fri Sat Mornings Afternoons Evenings Weekends		
Child's Mother's Maiden Name Child's City of Birth Special Needs Is your child in need of sp "Special needs child care or more chronic health co including social, emotional	ecial needs child care based " means child care provided to anditions or does not meet agal, cognitive, communicative.	Check all that apply Sun Mon Tues Wed Thurs Fri Sat Mornings Afternoons Evenings Weekends What is the child's home school district?		

Child 3	Provider Name and Address	What hours/days do you need services? (child care or preschool) Check all that apply
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat
		Mornings
		Afternoons
		Evenings
		□ MAtasta and
		Weekends
Child's Mother's Maiden Name		What is the child's home school district?
(tull)		
Child's City of Birth	1	
	ļ	
Special Needs		
is your child in need of spe	ecial needs child care based	on this definition?
or more obronic boolth on	means child care provided	to a child who is less than eighteen years of age and either has one
including social emotions	dullions or does not meet ag	le appropriate expectations in one or more areas of development,
may include on a regular l	n, cognitive, communicative, basis such services, adaptat	perceptual, motor, physical, and behavioral development and that itions, modifications, or adjustments needed to assist in the child's
function or development.	adaptat	ions, modifications, or adjustments needed to assist in the child's
Yes No		

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Tell us about your finances							
Will you or the people in your home receive income this month? ☐ Yes ☐ No							
Income refers to all the support, disability bene	e money that you and efits, retirement bene	the people in your fits, Workers' Comp	home receive such pensation, Social So	as earnings	from employment, c Veterans Benefits, e	:hild/spousal/medical	
If yes, please complete	the table below.			,, ,			
Name	Type of Income	Amount of Income (before taxes)	How Often Received (weekly, bi- weekly, etc)	Date Last Received	Work or School Schedule (please list times)		
	1				Sun	☐ Thurs	
					☐ Mon	Fri	
					Tues	☐ Sat	
					☐ Wed		
					Sun	☐ Thurs	
			ļ	'	☐ Mon	Fri	
					☐ Tues	☐ Sat	
					☐ Wed		
	1				Sun	[] Th	
			}		☐ Mon	Thurs	
					Tues	☐ Fri ☐ Sat	
					☐ Wed		
					☐ Sun	☐ Thurs	
					☐ Mon	☐ Fri	
					Tues	☐ Sat	
					☐ Wed		
					☐ Sun	Thurs	
					☐ Mon	Fri	
		}			☐ Tues	Sat	
					☐ Wed		
Do you or anyone to yo	ur household nov C	hild or Spanse! S					
Do you or anyone in your household pay Child or Spousal Support? Yes No How Much?							
Signature of Applicant					Date		

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