**TOWN OF WEST HARTFORD**

**SCHOOL READINESS PROGRAM APPLICATION**

**2018-2019 SCHOOL YEAR**

|  |  |
| --- | --- |
| Parent/Guardian | Parent/Guardian |
| Name: | Name: |
| Address: | Address: |
| Phone: | Phone: |
| Occupation: | Occupation: |
| Highest Grade Level Achieved (circle):  6 7 8 9 10 11 12 GED 13 14 15 16 17(+) | Highest Grade Level Achieved (circle):  6 7 8 9 10 11 12 GED 13 14 15 16 17(+) |
| Primary Language: | Primary Language: |

**You must reside in West Hartford to be eligible for this program**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Household Members  (list all) | Date of Birth | Race  (A,B,W,H,O) | Gender  (M/F) | Gross Income  Per Year |
|  |  |  |  | **$** |
|  |  |  |  | **$** |
|  |  |  |  | **$** |
|  |  |  |  | **$** |
|  |  |  |  | **$** |

*OTHER SOURCES OF INCOME (Child Support, Alimony, Etc.)*

|  |  |  |
| --- | --- | --- |
| Household Member’s Name | Source of Income | Amount per Year |
|  |  | $ |
|  |  | $ |

**INSURANCE & HEALTH INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the applicant child have: | Title 19 or  HUSKY Part A  Yes\_\_\_\_ No\_\_\_\_ | Private Health Insurance  Yes\_\_\_\_ No\_\_\_\_ | Any Kind of  Health Insurance  Yes\_\_\_\_ No\_\_\_\_ | A Primary Physician  Yes\_\_\_\_ No\_\_\_\_ |
| If the applicant child has a disability, does he/she have an IEP or IFSP? Yes \_\_\_\_ No\_\_\_\_ | | | | |
| Are you active on Section 8? Yes \_\_\_\_ No\_\_\_\_ | | | | |
| Do you receive any of the following services: WIC Domestic Violence Program  (please circle all that apply) DCF Involvement Care 4 Kids | | | | |

**Applicant parent/guardian to sign after reading the following agreement**

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

* I understand that if my child does not regularly attend the program, I may lose this subsidy.
* I further understand that continued eligibility for this subsidy is contingent upon appropriate, respectful behavior by me and by my son/daughter when dealing with anyone connected to this program.
* I am aware that failure to pay the program directly and in a timely manner will result in the loss of this subsidy.
* I am aware that re-determination of income is done every 6 months. In the case of unanticipated financial circumstances, I can request a re-determination sooner.
* I agree to abide by the specific policies and procedures of the School Readiness site. I understand I will need to review the Parent Handbook for this information.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Person Verifying Income:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY**

District of Residence:

Aiken: \_\_\_ Braeburn: \_\_\_ Bugbee: \_\_\_ Charter Oak: \_\_\_ Duffy: \_\_\_ Morley: \_\_\_

Norfeldt: \_\_\_ Smith: \_\_\_ Webster Hill: \_\_\_ Whiting Lane: \_\_\_ Wolcott: \_\_\_

Income/Demographic Info

Total Household Income; all sources: $\_\_\_\_\_\_\_\_\_ %SMI:\_\_\_\_\_\_\_ Monthly Family Share: $\_\_\_\_\_\_\_\_\_\_

Total # of persons in household: \_\_\_\_\_\_\_

Program Enrolled in:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_