



FOREST LAKE EARLY CHILDHOOD PROGRAMS

Sliding Fee Application

2012-13

Dear Parents,

Thank you for your interest in the Early Childhood programs. It is our goal that all children are able to attend class regardless of income.

Early Childhood offers sliding fees to assure that all families in the community have equal access to high quality programming. We rely on the fees that parents agree to pay when they register their child for class.

If you find your situation has changed and you are unable to make your monthly payments or your financial situation improves and you are no longer in need of reduced fees, please contact us so we can adjust your billing accordingly.

Families who apply:

- Agree to contact the teacher if their child is unable to attend class.
- Understand that if their child misses three sessions and they do not contact the teacher, regarding their child's absence, they may forfeit his/her spot.
- Understand they pay the initial registration fee for the program, unless other arrangements have been made.
- Understand that a parent/caregiver must participate in scheduled parent/child days.

If you would like to apply for sliding fees, please review all of the information in this packet, fill out the attached paperwork completely and return it with your child's registration. If you have questions about sliding fees please feel free to contact us at (651) 982-8349.

Thank you for your continuing support of Early Childhood programs,

Cindy Saarela
Forest Lake Schools Early Childhood Coordinator

Sliding Fees for parent child preschools are determined by annual family income	Monthly Tuition payable Sept 1, 2012 – May 1, 2013 (9 payments)			
	1/day/week monthly	2 days/week monthly	3 days/week monthly	Sibling care per child Monthly/Weekly
Over \$100,000	\$35	\$105	\$140	\$40/\$12
\$70,-\$100,000	\$30	\$85	\$110	\$30/\$9
\$40-\$70,000	\$20	\$65	\$85	\$20/\$6
\$20-\$40,000	\$15	\$45	\$55	\$15/\$4.50
Under \$20,000	\$10	\$25	\$30	\$5/\$1.50



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Today's Date: _____

Child's name: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Who is the primary weekday caregiver? (circle one) Mother Father Other _____

Child's Address: _____ City _____ Zip Code _____

Phone: _____ County _____

Mother's Address if different: _____

Mother's Phone if different: Home: _____ Cell _____

Father's Address if different _____

Father's Phone if different: Home: _____ Cell _____

In order to help us better serve you, please check all of the answers that apply to your child or family.

My child

_____ completed Early Childhood Screening (date screened: _____)

_____ is not currently enrolled in any other preschool program

_____ has never attended preschool classes

_____ does not speak English

_____ is bilingual. (what is your child's first language? _____, second language? _____)

_____ is receiving Special Education services and has an Individualized Education Plan (IEP)

_____ has been referred for special education services but did not qualify

_____ has a history of frequent or chronic illness

_____ was born after a high risk pregnancy

Are there other concerns about your child's health and development that you would like us to know about?

Our family.....

_____ has a father or mother absent from the family

_____ has experienced financial challenges in the past year (loss of income, wage/benefit reduction).

_____ has changed residence two or more times in the past year

_____ does not speak English at home

_____ has an immediate family member who has a history of frequent or chronic illness

_____ receives support from other social agencies in the community

_____ qualifies for free or reduced-priced school lunch

_____ is homeless

Are there other family factors or circumstances that you would like us to know about?

- I have completed the required Application for Educational Benefits
- I have completed the questionnaire
- I signify that the information provided on this application is true and correct.

Signature of Parent _____

Date _____



Application for Early Childhood Educational Benefits

School Year 2012-13 • State and Federally Funded Programs for Schools

Mail or fax form to:
 Forest Lake Schools
 Early Childhood Programs
 200 SW 4th Street
 Forest Lake, MN 55025
 Fax: (651) 982-8375

Names of All Children In Household		Date of Birth	Early Childhood Class	If applicable SSI or Other Regular Income to Child
First Name	Last Name	Month/Day/Year	Enrollment (use class #)	
1				\$ _____ per _____
2				\$ _____ per _____
3				\$ _____ per _____
4				\$ _____ per _____
5				\$ _____ per _____

List *all adults* in the household, *all incomes*, and *how often* each income is received. Attach an additional page if necessary

Names of All Adults in Household (all household members not listed in Section 1)		<i>Check this column if person has NO Income</i>	Incomes Write in each gross income and how often it is received: weekly , bi-weekly (every 2 weeks), twice per month , monthly , or yearly . Do <i>not</i> write in hourly pay. If income fluctuates, write in the amount normally received.				
First Name	Last Name		Gross Wages and Salaries from all jobs - before deductions -	Pension, SSI, Retirement, Social Security	Public Assistance, Child Support, Alimony	Unemployment, Worker's Comp, Strike Benefits	Any Other Income, including <i>net</i> Farm/ Self-Employment
1			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
2			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
3			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
4			\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____

I certify that the information provided on this application is true and correct. Because federal and state funds may be paid on the basis of this information, I understand that school and state officials may verify the information, and that deliberate misrepresentation may subject me to prosecution under applicable laws.

Signature of Adult Household Member (required) _____ **Print Name:** _____ **Date:** _____
Social Security number –last 4 digits (required) _____
 Address: _____ City _____ Zip _____
 Home Phone: _____ Work Phone: _____

Sliding Fees Determined by annual family income	Monthly Tuition (Sept – May)			
	1/day/week	2 days/week	3 days/week	Sibling care /child
Over \$100,000	\$35	\$105	\$140	\$40
\$70,-\$100,000	\$30	\$85	\$110	\$30
\$40-\$70,000	\$20	\$65	\$85	\$20
\$20-\$40,000	\$15	\$45	\$55	\$15
Under \$20,000	\$10	\$25	\$30	\$5

Office Use Only

Total Household Size: _____ Total Incomes: \$ _____ per year
 Approve for monthly fee: _____ Sibling care: _____
 Fee approved until: _____
 Staff signature: _____ Date: _____