Northwest Michigan Action Agency
Head Start & Great Start Readiness Program

RELEASE TO SERVE A HEAD START ELIGIBLE CHILD INTO A GSRP PROGRAM

Date Sent to Head Start: _____

Child's Name:_____

Child's Birth Date: _____

Parent Name(s): _____

Address and County: _____,_____,_____,_____

Telephone Number /e-mail: _____

School District of Residence: _____

EXPLANATION OF FAMILY PROGRAM PREFERENCE

Although my child is Head Start eligible, my preference is to apply to the Great Start Readiness Program (GSRP).

Reason for Preference:

Parent/Guardian/Foster Signature:_____

The above family is under consideration for enrollment in the GSRP program operated by:

_____

If the GSRP program has space for this child and with the signed permission below can enroll this child for this school year.

GSRP School Staff Signature and Title: _____

Head Start Staff Signature and Title: _____

Head Start Date Signed: _____

To be completed by GSRP Personnel and e-mailed to Alicia Temple, atemple@nmcaa.net or another Head Start Staff

Application Notes

Application Expiration Date:_____

FOR DMT USE ONLY:
CPID:

Early Head Start Eligibility Verification

1. Applicants Name_____ 2. Applicants Date of Birth_____

3. Parent/Guardian/Foster

A01_____ A02_____

4. Preferred Site

1_____ 2_____

5. Type of eligibility interview conducted? In-Person

6. Indicate the applicable eligibility criterion for this child:

☐ Experiencing Homelessness ☐ Foster Care ☑ Public Assistance: FIP, SNAP, SSI

Head Start

☐ 0-100% of FPL
☐ Between 101-130% of FPL
☐ Over-Income-131% and greater FPL

*45 CFR 1302.12(c)(2) specifies that a program may enroll a child who would benefit from services but does not meet other eligibility requirements provided that these participants only make up to 10 percent of a program's enrollment or 49 percent in the case of AI/AN programs as described in 45 CFR 1302.12(e).
**45 CFR 1302.12(d) specifies that a program may enroll an additional 35 percent of participants whose families do not meet any other eligibility criterion and whose incomes are below 130 percent of the poverty line.

7. What documentation was used to determine eligibility and is included as part of the eligibility determination record?

☐ Tax Forms
☐ W-2
☐ MDHHS FIP/SNAP
☐ Pay Stubs
☐ UIA (Unemployment)
☐ Third Party
☐ FIS (Family Income Status)
☐ McKinney-Vento
☐ Foster Care Reimbursement
☐ SSI
☐ Child Support
☐ Other - please explain _____

8. How did hear about applying for a program? _____

9. What are your favorite things about your family? _____

10. If child has siblings, which school do they attend? _____

Certification: *Knowingly falsifying documents and determining a child eligible for Head Start when the child does not meet the eligibility criteria can lead to criminal charges.*

11. Staff Signature_____ Date_____

12. Staff Name_____ Title_____

13. Verifying Staff Signature _____ Date Verified_____

GSRP Quintile_____% ☐ 2022-2023 ☑ 2023-2024

FOR DMT USE ONLY:
CPID:

Head Start/GSRP Eligibility Verification

1. Applicants Name_____ 2. Applicants Date of Birth_____

3. Parent/Guardian/Foster

A01_____ A02_____

4. Preferred Site

1_____ 2_____

5. Type of eligibility interview conducted? In-Person

6. Indicate the applicable eligibility criterion for this child:

☐ Experiencing Homelessness ☐ Foster Care ☑ Public Assistance: FIP, SNAP, SSI

Head Start	GSRP
☐ 0-100% of FPL	☐ At or below 250% FPL
☐ Between 101-130% of FPL	☐ Above 250% FPL
☐ Over-Income-131% and greater FPL	☐ GSRP Early Entry

Head Start Returning Child?_____ Program Year_____

*45 CFR 1302.12(c)(2) specifies that a program may enroll a child who would benefit from services but does not meet other eligibility requirements provided that these participants only make up to 10 percent of a program's enrollment or 49 percent in the case of AI/AN programs as described in 45 CFR 1302.12(e).
**45 CFR 1302.12(d) specifies that a program may enroll an additional 35 percent of participants whose families do not meet any other eligibility criterion and whose incomes are below 130 percent of the poverty line.

7. What documentation was used to determine eligibility and is included as part of the eligibility determination record?

☐ Tax Forms	☐ FIS (Family Income Status)
☐ W-2	☐ McKinney-Vento
☐ MDHHS FIP/SNAP	☐ Foster Care Reimbursement
☐ Pay Stubs	☐ SSI
☐ UIA (Unemployment)	☐ Child Support
☐ Third Party	☐ Other - please explain _____

8. How did hear about applying for a program? _____

9. What are your favorite things about your family? _____

10. _____ Parent prefers a 4-hour program _____ Parent prefers a 7-hour program

11. _____ Parent prefers busing _____ Parent will transport _____ Parent has no transportation

12. If child has siblings, which school do they attend? _____

Certification: *Knowingly falsifying documents and determining a child eligible for Head Start when the child does not meet the eligibility criteria can lead to criminal charges.*

13. Staff Signature_____ Date_____

14. Staff Name_____ Title_____

15. Verifying Staff Signature _____ Date Verified_____

Preferred Placement 1 2	School District	Class Age Based on Program Year	GSRP Age Eligible GSRP Early Entry	GSRP Eligibility Factors	EHS Transition EHS Staff _____

1. Street Address Zip Code County	City State Michigan	PO Box# State Michigan Zip Code City

2. First / Last Name of Parent/Guardian/Foster	DOB	Gender	Educ. Level	Present Employment Status	Email Address	Phone Number/Txt
A01						
A02						

Parental/Guardian Status
Pregnant Mother/Expectant Father Due Date_____
Current Teen Parent
Custody Agreement
Military Status
Write notes in box 20.

3. First / Last Name of Applicant	DOB	Gender	Related To	How Related	Ethnicity Hispanic/Latino	Race
C01						

4. First / Last Name of Children	DOB	Gender	Related To	How Related	First and Last Name of Children	DOB	Gender	Related To	How Related
C02					C06				
C03					C07				
C04					C08				
C05					C09				

5. Number of People in Family Number of Children in Family Birth to 3 Years Old

6. Primary Language Spoken in Home
Secondary Language
Is anyone in the home acquiring or learning another language in addition to English?
Language acquiring or learning.

7. Do you currently receive? WIC Healthy Families America MDHHS Child Care Subsidy Maternal Infant Health Program (MIHP)

8. Related to an NMCAA employee? If yes, first/last name of employee and relationship to applicant.

9. Were they professionally referred to the program? By Who? Why?

10. Health Insurance
Dental Insurance
Medical Provider and/or Office
Dental Provider and/or Office

11. Medically Diagnosed Allergies
Describe
Chronic/Serious Health and/or Dental Conditions
Describe

12. Diagnosed Disability with Current IEP/IFSP ☐ Y ☐ N
Describe
Suspected Disability
Describe
Special Accommodations Needed
Describe

Check all that apply

13. ☐ Income: ☐ Low income at or below 250% FPL ☐ 251% - 300% FPL **GSRP #1**
☐ 301% - 350% FPL ☐ 351% and above FPL

14. ☐ Diagnosed Disability or Identified Developmental Delay: ☐ IEP ☐ Early On ☐ Doctor Report ☐ Screening Tool **GSRP #2**

15. ☐ Severe or Challenging Behavior: Expelled From Medical or Mental Health Referal **GSRP #3**

16. ☐ Primary Home Language Other than English: Child's Primary Language Child's Home Language **GSRP #4**

17. ☐ Parent/Guardian(s) with Low Educational Atainment: Father Mother Note: **GSRP #5**

18. ☐ Abuse/Neglect of Child or Parent: ☐ Child: ☐ Drugs ☐ Alcohol ☐ Physical ☐ Parent: ☐ Drugs ☐ Alcohol ☐ Physical **GSRP #6**
☐ Person in the Home: ☐ Drugs ☐ Alcohol ☐ Physical ☐ Family Member: ☐ Drugs ☐ Alcohol ☐ Physical
Note

19. ☐ Environmental Risk ☐ Loss of Parent/Reason ☐ Teen Parent(not yet 20 at birth of 1st child)/Age **GSRP #7**
Sibling Issues: ☐ Chronic Illness ☐ Behavioral Issues ☐ Disability ☐ Death Note
Homeless or Without Stable Housing: ☐ Shelter ☐ Transitional Housing ☐ Doubled Up ☐ Hotel/Motel ☐ Unsheltered
☐ Residence in High Risk Neighborhood ☐ Prenatal Exposure to Toxic Substances Note

20. Eligibility Notes/Additional Information

21. Income: Family Member	Source/Employer	Annual Income	Income Verified By: ☐ Tax Forms ☐ W2 ☐ Pay Stubs ☐ UIA ☐ Child Support
			☐ MDHHS ☐ 3rd Party ☐ FIS ☐ McKinney-Vento ☐ SSI ☐ Foster Care ☐ Other
			Age Verified By: ☐ Certified Birth Certificate ☐ Hospital Birth Certificate
			☐ MCIR ☐ MDHHS ☐ Court Documents ☐ Other

22. Eligibility Criterion: ☐ Foster/Kinship Care ✔ SSI/FIP/SNAP ☐ Homeless

Total Yearly Income $ 0.00

HS/ EHS Eligibility: ☐ Eligible ☐ OI Returning 2nd Year Eligibility
GSRP Eligibility: ☐ Eligible ☐ OI

23. **RELEASE OF APPLICATION INFORMATION AND SHARING OF EARLY CHILDHOOD APPLICATION INFORMATION**

To increase the likelihood of my child benefiting from an early childhood educational experience, I, parent/guardian/foster, authorize Early Head Start, Head Start, Tribal Head Start, Non-profit Licensed School Readiness Programs, the Local School District, the Intermediate School District and District Partners to share family/child application/eligibility information. This authorization shall remain in effect for two years from the signature date. Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

Child's Name _____ Date of Birth _____ Parent/Guardian/Foster Signature _____ Date _____

24. Certification: *I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during business hours.*

Parent/Guardian/Foster Signature _____ Date _____

25. Signature of Verifying EHS/HS/GSRP Staff Member:_____ Date: _____

Preferred Placement 1 2	School District	Class Age Based on Program Year	GSRP Age Eligible GSRP Early Entry	GSRP Eligibility Factors	EHS Transition EHS Staff _____

1. Street Address Zip Code County	City State Michigan	PO Box# Zip Code	State Michigan City

2. First / Last Name of Parent/Guardian/Foster	DOB	Gender	Educ. Level	Present Employment Status	Email Address	Phone Number/Txt
A01						
A02						

Parental/Guardian Status
Pregnant Mother/Expectant Father Due Date_____
Current Teen Parent
Custody Agreement
Military Status
Write notes in box 20.

3. First / Last Name of Applicant	DOB	Gender	Related To	How Related	Ethnicity Hispanic/Latino	Race
C01						

4. First / Last Name of Children	DOB	Gender	Related To	How Related	First and Last Name of Children	DOB	Gender	Related To	How Related
C02					C06				
C03					C07				
C04					C08				
C05					C09				

5. Number of People in Family Number of Children in Family Birth to 3 Years Old

6. Primary Language Spoken in Home
Secondary Language
Is anyone in the home acquiring or learning another language in addition to English?
Language acquiring or learning.

7. Do you currently receive? WIC Healthy Families America MDHHS Child Care Subsidy Maternal Infant Health Program (MIHP)

8. Related to an NMCAA employee? If yes, first/last name of employee and relationship to applicant.

9. Were they professionally referred to the program? By Who? Why?

10. Health Insurance
Dental Insurance
Medical Provider and/or Office
Dental Provider and/or Office

11. Medically Diagnosed Allergies
Describe
Chronic/Serious Health and/or Dental Conditions
Describe

12. Diagnosed Disability with Current IEP/IFSP ☐ Y ☐ N
Describe
Suspected Disability
Describe
Special Accommodations Needed
Describe

Check all that apply

13. ☐ Income: ☐ Low income at or below 250% FPL ☐ 251% - 300% FPL **GSRP #1**
☐ 301% - 350% FPL ☐ 351% and above FPL

14. ☐ Diagnosed Disability or Identified Developmental Delay: ☐ IEP ☐ Early On ☐ Doctor Report ☐ Screening Tool **GSRP #2**

15. ☐ Severe or Challenging Behavior: Expelled From Medical or Mental Health Referal **GSRP #3**

16. ☐ Primary Home Language Other than English: Child's Primary Language Child's Home Language **GSRP #4**

17. ☐ Parent/Guardian(s) with Low Educational Atainment: Father Mother Note: **GSRP #5**

18. ☐ Abuse/Neglect of Child or Parent: ☐ Child: ☐ Drugs ☐ Alcohol ☐ Physical ☐ Parent: ☐ Drugs ☐ Alcohol ☐ Physical **GSRP #6**
☐ Person in the Home: ☐ Drugs ☐ Alcohol ☐ Physical ☐ Family Member: ☐ Drugs ☐ Alcohol ☐ Physical
Note

19. ☐ Environmental Risk ☐ Loss of Parent/Reason ☐ Teen Parent(not yet 20 at birth of 1st child)/Age **GSRP #7**
Sibling Issues: ☐ Chronic Illness ☐ Behavioral Issues ☐ Disability ☐ Death Note
Homeless or Without Stable Housing: ☐ Shelter ☐ Transitional Housing ☐ Doubled Up ☐ Hotel/Motel ☐ Unsheltered
☐ Residence in High Risk Neighborhood ☐ Prenatal Exposure to Toxic Substances Note

20. Eligibility Notes/Additional Information

21. Income: Family Member	Source/Employer	Annual Income	Income Verified By: Tax Forms W2 Pay Stubs UIA Child Support
			MDHHS 3rd Party FIS McKinney-Vento SSI Foster Care Other
			Age Verified By: Certified Birth Certificate Hospital Birth Certificate
			MCIR MDHHS Court Documents Other

22. Eligibility Criterion: ☐ Foster/Kinship Care ✔ SSI/FIP/SNAP ☐ Homeless

Total Yearly Income

HS/ EHS Eligibility: ☐ Eligible ☐ OI Returning 2nd Year Eligibility
GSRP Eligibility: ☐ Eligible ☐ OI

23. **RELEASE OF APPLICATION INFORMATION AND SHARING OF EARLY CHILDHOOD APPLICATION INFORMATION**

To increase the likelihood of my child benefiting from an early childhood educational experience, I, parent/guardian/foster, authorize Early Head Start, Head Start, Tribal Head Start, Non-profit Licensed School Readiness Programs, the Local School District, the Intermediate School District and District Partners to share family/child application/eligibility information. This authorization shall remain in effect for two years from the signature date. Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

Child's Name _____ Date of Birth _____ Parent/Guardian/Foster Signature _____ Date _____

24. Certification: *I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during business hours.*

Parent/Guardian/Foster Signature _____ Date _____

25. Signature of Verifying EHS/HS/GSRP Staff Member:_____ Date: _____

nmcaa
Head Start/Early Head Start

Great Start Readiness Program

Family Income Status / Staff Documentation

The information below is a self declaration that is deemed necessary to verify eligibility and will be used to determine the income status of your family, which is required for any federal or state child development programs such as Head Start, Early Head Start or GSRP.

Parent or Guardian Name(s) _____

Child Applicant's Name_____

Check all that apply

_____My family declares we have no income.

_____My family is declaring we have income, but are unable to provide income documentation.
(Complete Third Party Documentation for consent to obtain income documentation from employer)

_____My family declares income received through cash in the amount of $_____

Time frame worked _____

_____My family has not received child support in the last year.

_____My family has not received unemployment in the last year.

_____My family has not received college/university grants or scholarships in the last year.

_____Other_____

Parent Comments

I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and I may be subject to legal action.

Parent / Guardian Signature_____ Date_____

Staff Verification Log of attempts by staff to secure income verification documents.

I have made reasonable efforts to verify eligibility information for the above stated family/child

Verifying Staff Signature _____ Date _____

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Head Start/Early Head Start

Third Party Documentation

Great Start Readiness Program

I give consent for Northwest Michigan Community Action Agency (NMCAA) to seek documentation from the below stated party to verify my current living/income status.

Parent/Guardian Signature _____ Date _____

Third Party Name_____

Relationship to Family_____

Child's Name_____

Parent / Guardian Name(s)_____

Regarding the family above, please indicate all that apply below:

☐ I acknowledge that I provide housing

☐ I acknowledge that I provide daily living expenses

☐ I acknowledge that I provide a monthly cash amount of _____

Third Party's Signature _____ Date _____

If family is unable to provide income documentation as noted on the Family Income Status form, current or former employer will complete the section below.

Employed at _____ within the last 12 months.

To be completed by employer

I acknowledge that _____ is/was an employee

Yearly Gross wages_____

Employer signature_____ Date_____

Please return by fax at or e-mail to _____

Other explanations or comments

_____

_____

_____

_____

_____

Early Head Start Child Care Partnership
Child Development and Care Subsidy Documentation

The why?

The Early Head Start Child Care Partnership (EHS CCP) is funded through the State of Michigan Child Development and Care (CDC) subsidy and federal funding from the Office of Head Start. These two sources are necessary to provide *all* of the wonderful EHS CCP services. All eligible families are required to apply for CDC subsidy prior to enrolling in an EHS CCP program.

Parent or Guardian Section

Please select and complete one of the options for applying below.

- ☑ I will complete the online application for CDC subsidy by _____(date). (https://newmibridges.michigan.gov/s/isd-landing-page?language=en_US)
    - If you have any questions about the CDC subsidy application process, please see the State of Michigan MIBridges help page: https://newmibridges.michigan.gov/s/isd-prelogin-help?language=en_US

OR

- ☐ I have received the paper application for CDC subsidy and will complete and submit it to DHHS by _____(date).

OR

- ☐ I previously applied for CDC subsidy and was denied on _____ (date) and will submit a record of denial to the director at my childcare center.

OR

- ☐ I am currently enrolled to receive payment assistance for child care services through the CDC Payment Assistance program.

OR

- ☐ I have not applied because I am not eligible due to the following reasons:

- If my circumstances change, I will notify the center director and reapply.

Signature: _____ Date: _____

Next Steps for EHS CCP Enrollment

- ✔ A NMCAA Family Specialist will contact you to collect documentation on the status of your CDC subsidy application.

Distribution: Attach with application in CP and copy to center director at acceptance

Disclosure with Parental Consent

I, _____, hereby authorize the sharing of
(Parent/Guardian)

_____
(Clearly state what information/records may be shared)

regarding _____, _____
(First and Last Name) (Date of Birth)

between Northwest Michigan Community Action Agency, Inc. and

_____,
(School District, Agency, Professional, Other)

_____,
(Address)

_____,
(City, State, Zip)

Reason for Record Disclosure Request:

_____

Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

_____ _____
Parent/Guardian Signature Date

Not to exceed two years from the signature date, or upon exit of the program.

Disclosure with Parental Consent

I, _____, hereby authorize the sharing of
(Parent/Guardian)

_____
(Clearly state what information/records may be shared)

regarding _____, _____
(First and Last Name) (Date of Birth)

between Northwest Michigan Community Action Agency, Inc. and

_____,
(School District, Agency, Professional, Other)

_____,
(Address)

_____,
(City, State, Zip)

Reason for Record Disclosure Request:

_____

Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

_____ _____
Parent/Guardian Signature Date

Not to exceed two years from the signature date, or upon exit of the program.

Families in Transition Questionnaire

Name of Child_____ Child's Date of Birth_____

County of Residence _____ Date of Questionnaire_____

Your child may be eligible for free additional services through the federal McKinney-Vento Assistance program. Eligibility will be determined by completing this questionnaire.

1. Where are you and your family currently staying? *Check one box*

- [x] Sharing the housing of another family member or friend (doubling-up) due to loss of housing, economic hardship, or similar reason.
- [ ] Living in a motel, hotel, RV park, or campground
- [ ] Staying in an emergency or transitional shelter (ex. Goodwill Inn, Women's Resource Center)
- [ ] Living in a vehicle, park, public space, abandoned building, or other place not designed for or ordinarily used as a regular sleeping place for human beings
- [ ] Living in substandard housing without running water, electricity, or heat (no windows, overcrowded, sleeping in a common area of house-living room, dining room, basement, etc.
- [ ] I am a minor parent not living with a parent or legal guardian.
- [ ] None of the above/other:_____

2. Answer all questions below.

Where were you living before this?_____

What prompted you to move?_____

How long do you plan to stay where you are now? _____

Could your friend/relative ask you to leave?_____

Where would you go if you were asked to leave?_____

The undersigned certifies that the information provided above is accurate.

_____	_____	_____	_____
Parent/Guardian Signature	Printed Name	Date	Phone #
_____	_____	_____	_____
Staff Person Signature	Printed Name	Date	Phone #

Disclosure with Parental Consent must be attached and sent to the Homeless Liaison.

Office use only:

- [ ] Sent to MV Coordinator/Date _____
- [ ] Yes, student is eligible for MV services, Initials and Date_____
- [ ] No, not eligible as MV

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Head Start/Early Head Start

Release of Health Information

Great Start Readiness Program

As Parent/Guardian of _____, born _____,

Please Print Child's Name Child's Date of Birth

I hereby request and authorize Northwest Michigan Community Action Agency's Child Development Program and/or Intermediate School District Child Development Program to access my child's health screening which may include; most recent well-child exam, hearing screening, vision screening, blood pressure, hematocrit/ hemoglobin, growth assessment, blood lead screening, immunizations record, any other health referrals/ recommendations. These records will be used to meet the Head Start Standards and Michigan Child Care Licensing Rules in order to participate in preschool programming and support each child's growth and school readiness. Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

_____ Last or Next Exam Date

_____ Medical Provider and/or Office

_____ Phone Number

_____ Address / City

_____ Parent/Guardian: Signature

_____ Printed Name

_____ Date

Not to exceed two years from the signature date, or upon exit of the program.

☐ Yes, I give permission for the Program Staff and/or Health Department to conduct hearing, vision, blood pressure, or non-invasive hematocrit and growth assessment screenings on my child if needed to complete the Head Start Health Requirements. I understand that I will receive the results of the screenings.

☐ No, I do not give permission for the Program Staff and/or Health Department to conduct the above screenings. Please explain why:_____

_____ Parent/Guardian: Signature

_____ Printed Name

_____ Date

Not to exceed two years from the signature date, or upon exit of the program.

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Head Start/Early Head Start

Release of Oral Health Information

As Parent/Guardian of _____, born _____,
Please Print Child's Name Child's Date of Birth

I hereby request and authorize Northwest Michigan Community Action Agency's Child Development Program and/or Intermediate School District Child Development Program to receive/share my child's most recent oral health screening which must include; exam, prophy, fluoride, x-rays (only if required for diagnostic use) and any other dental referrals/recommendations. These records will be used to meet the Head Start Standards in order to support each child's growth and school readiness. Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

_____ _____
Last or Next Oral Health Screening Date Dentist's Name and/or Office

_____ _____
Phone Number Address / City

_____ _____ _____
Parent/Guardian: Signature Printed Name Date

Not to exceed two years from the signature date, or upon exit of the program.

How did you hear about us?

CUSTOMER CONNECTION FORM

To better serve and connect you with as many programs as will fit your needs, please fill out form completely.

Referring Department:
Child and Family Development

1. Are you currently homeless or at risk of becoming homeless?

   *Call **844.900.0500** for immediate assistance*

2. Would you like information on making your home more energy efficient to lower your heating costs? [Weatherization]
3. Do you need help with heating or energy bills? [Utility Assistance]
4. Are you a homeowner whose home needs repairing?

   If yes, what?_____[Housing Rehabilitation]

5. Would you like to have your taxes prepared for free? [Tax Preparation]
6. Do you have questions about the Home Heating Credit or the Earned Income Credit? [Tax Preparation]
7. Would you like to have help budgeting your money? [Budget Counseling/Workshops]
8. Would you like more information about our IDA Savings Account that helps you buy a home, go back to school, or start a business? [Budget Counseling/IDA]
9. Are you considering bankruptcy education? [Pre/Post Bankruptcy Counseling]
10. Are you interested in learning about food assistance programs? [Food Programs]
11. Do you know someone who is homebound, 60+ years old, and unable to cook for themselves, and would like meals delivered to their home? [Meals on Wheels]
12. Do you have trouble making your rent/mortgage payment on time each month? [Foreclosure Prevention/Housing Counseling]
13. Are you interested in learning about owning your own home? [Homeownership Couching/Workshops]
14. Are you in the process of looking for a new home/apartment to rent? [Rental Counseling]
15. Would you like more information about adequate childcare for when you work or go to school? [Collaborative Center]
16. Would you like more information about preschool opportunities for your 3-4 year old? [Head Start/GSRP]
17. Would you like more information about developmental opportunities and information for pregnant woman to 3 year old? [Early Head Start Home Based]
18. Are you interested in a Center Based Program for your child ages 0-3? [Early Head Start Expansion]

I authorize NMCAA to share my information within the agency for referral purposes.

Consent is voluntary, remains in effect for one year, and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

Name (printed):_____

County:_____Phone Number:_____Email:_____

Signature:_____Date:_____

Distribution: Mail completed form to-FMS Intake 3963 Three Mile Rd, Traverse City MI 49686 or email at fmsintake@nmcaa.net. Copy-in child's file

04/22