



solana beach school
district

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Jodee Brentlinger

August 21, 2020

Dear Parent/Guardian:

The Solana Beach Child Development Center (CDC) is offering a limited number of Preschool scholarships for the 2020-21 School Year. The scholarships are offered at the Solana Beach CDC location with a daily schedule of Monday through Friday, 7:00am to 4:00pm. To be eligible for scholarship consideration, you must meet the following criteria:

- Your child is Preschool age eligible (3-5). Your child must be three (3) by September 1, 2020 and must be fully toilet trained.
- You qualify for the California Department of Education, Child and Adult Care Food Program (CACFP).
- You reside within the boundaries of the Solana Beach School District (in the event a joint custody arrangement exists between two parents, the student must sleep at the home of the parent residing in the district at least three (3) school days per week).
- You have no outstanding balance with any Solana Beach Child Development Center program.

To apply for the CDC Preschool Scholarship, please complete the attached application and eligibility form. Return the completed documents to:

Solana Beach Child Development Center
Preschool Scholarship
309 N. Rios Ave.
Solana Beach, CA 92075

A limited number of scholarships will be awarded on a first-come, first-serve basis (pending review of application requirements). Please submit your application between August 21 and August 28, 2020 for review. You will be notified of the decision within ten (10) business days from the close of the application submission period.

Feel free to contact the CDC Office if you have any additional questions at (858) 794-7160.

Sincerely,


Jodee Brentlinger
Superintendent

**Solana Beach Child Development Center
Preschool Scholarship Application**

Location: Solana Beach CDC - 309 N. Rios Ave., Solana Beach, CA 92075
Schedule: Monday - Friday 7:00am to 4:00pm

School Year: 2020 - 21

Child's Name: _____	Birthdate: _____
	Age: _____
Parent/Guardian 1 Name: _____	Phone: _____
Address: _____	Email: _____
Name of Employer or School: _____	Phone: _____
Employer or School Address: _____	_____
Parent/Guardian 2 Name: _____	Phone: _____
Address: _____	Email: _____
Name of Employer or School: _____	Phone: _____
Employer or School Address: _____	_____

Initial on the lines below for each of the following statements to certify that you have read and understand the guidelines for a Solana Beach Child Development Center (SBCDC) child care scholarship.

_____ I understand that to be eligible for a Preschool scholarship I must meet the following criteria:

- ◆ *My child must be three (3) by September 1, 2020 and must be fully toilet trained.*
- ◆ *My family qualifies for the California Department of Education, Child and Adult Care Food Program (CACFP)*
- ◆ *We reside within the boundaries of the Solana Beach School District (in the event a joint custody arrangement exists between two parents, the student must sleep at the home of the parent residing in the district at least three (3) school days per week)*
- ◆ *I have no outstanding balance with any SBCDC program.*

_____ I understand that ALL information on this application is subject to verification.

_____ I understand that falsifying or omitting any information requested will disqualify the applicant from the scholarship eligibility process.

_____ I understand that all applications will be considered in the order received, and that this scholarship is only for the 2020 - 21 school year (summer programs not included).

_____ I understand transportation is not provided, and I am responsible for the drop-off and pick-up of my child during the designated drop-off/pick-up times.

_____ I understand that if my application is incomplete or if any attachments are missing, my application will be returned as incomplete. This may cause a delay in approval or possible ineligibility.

_____ I understand the scholarship is available for full-time attendance, Monday through Friday 7:00am to 4:00pm. Absences must be for illness or necessity. Consistent absences could result in a loss of scholarship.

_____ I understand that I am responsible for any late pick-up fees on my account.

_____ I certify that all of the information provided above is true and correct. I have read and understand the above policies and procedures.

Signature of Parent/Legal Guardian

Date

*Applicants without income are requested to write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

Printed Name:	
Last Four Digits of SSN:	<input type="checkbox"/> Check here if no SSN
Signature of Adult:	Date:

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or FDPIR case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

If you choose to do so, please mark one or more of the following racial identities:		
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White
Please mark one of the following ethnic identities:		
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at <https://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer> and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture
 Office of the Assistant Secretary for Civil Rights
 1400 Independence Avenue, SW
 Washington, D.C. 20250-9410
- (2) Fax: 202-690-7442
- (3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

FOR AGENCY USE ONLY	
CATEGORICAL ELIGIBILITY	
CalFresh/CalWORKS/FDPIR household categorically eligible free? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Foster child automatically eligible free? <input type="checkbox"/> Yes <input type="checkbox"/> No	
INCOME ELIGIBILITY Annual Conversion: Weekly times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Month 12	
Total Income:	Household Size:
Eligibility Classification <input type="checkbox"/> Free <input type="checkbox"/> Reduced-price <input type="checkbox"/> Base	
Determining Official (Print Name):	
Determining Official Signature :	Certification Date:

HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the MBF to:

If you need help, call:

1. CHILD INFORMATION:

- a) Print your child's name. Print your child's name.
- b) Check box to right of name if a foster child.
- c) Include the name of the child care center.

2. BENEFITS: Complete this section and sign the form in #4.

- a) List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
- b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. ALL OTHER HOUSEHOLDS: Complete this section and sign the form in #4.

Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. **If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.**

- a) Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
- b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
- c) Sign the form and include the last four digits of your SSN in #4. If you do not have a SSN, check the box "Check here if no SSN."

4. LAST FOUR DIGITS OF SSN AND SIGNATURE:

- a) The form must have a **signature** of an adult household member.
- b) The adult household member who signs the statement must include the last four digits of their **SSN**. If they do not have a SSN, check the box "Check here if no SSN". The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs, or FDPIR case number.

5. RACIAL/ETHNIC IDENTITY: You **are not required** to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT		
<p>Earnings from Work:</p> <ul style="list-style-type: none"> • Wages/salaries/tips • Strike benefits • Unemployment compensation • Worker's compensation • Net income from self-employment <p>Child Support/Alimony</p> <ul style="list-style-type: none"> • Public assistance payments • Alimony/child support payments 	<p>Pensions/Retirement/Social Security</p> <ul style="list-style-type: none"> • Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security 	<p>Other Monthly Income</p> <ul style="list-style-type: none"> • Disability benefits • Cash withdrawn from savings • Interest dividends • Income from estates/trusts/investments • Regular contributions from persons not living in the household • Net royalties/annuities/net rental income • Military allowance for off-base housing • Any other income

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

ETHNICITY

Hispanic or Latino

Not Hispanic or Latino