



**Preschool Open Doors (POD) Application Period
January 2, 2020 to March 31, 2020**

The Department of Human Services (DHS), Benefit, Employment and Support Services Division (BESSD) has begun accepting applications for the 2020-2021 Preschool Open Doors (POD) program. **The application period is January 2, 2020 to March 31, 2020.**

Children born between August 1, 2015 and July 31, 2016 are eligible to apply for the 2020-2021 POD year. Income eligibility limits apply (see below).

Monthly Gross Income Limits

<u>Family Size</u>	<u>Gross Income Limits</u>
1	2,755
2	3,718
3	4,680
4	5,643
5	6,605
6	7,568
7	8,530
8	9,493

The POD program helps eligible Hawaii families pay preschool fees for up to one year during the year prior to kindergarten entry. Priority enrollment goes to underserved or at-risk children whose families complete the POD Special Populations Referral form. The DHS 913A POD form is included in the POD application packet.

To be considered for the 2020-2021 POD year, **the POD office must receive your application by the March 31, 2020 deadline.** Applications post-marked, but not received by March 31, 2020, will not be considered.

Submitting an application does not guarantee acceptance into the POD program. The POD office will mail applicants notification of their application status, no later than April 30, 2020. Depending on your child's preschool start date, POD assistance may cover enrollment from July 1, 2020 through June 30, 2021.

If your family is selected, upon receipt of all required POD enrollment documents, including your selection of the preschool that meets your child's needs, your child will be enrolled. If you are not selected for the POD program, your application may be placed on a waiting list. These wait-listed applicants may be selected for future POD participation if funds become available.

The DHS administers the POD program. For more information about POD, call (808) 791-2130 on Oahu, or toll-free from the neighbor islands at (800) 746-5620.

Aloha,

PATCH
Preschool Open Doors
560 N. Nimitz Hwy, Ste. 218
Honolulu, HI 96817



PRESCHOOL OPEN DOORS
INSTRUCTION SHEET AND DOCUMENT CHECKLIST FOR APPLICATION

REQUIRED DOCUMENTS--The following documents are required to determine eligibility. Enclose **COPIES** of these documents with your signed application. Please note that **INCOMPLETE** applications **CANNOT BE PROCESSED** and **WILL BE DELAYED**.

REQUIRED:

APPLICATION

- Family Information - **Do not** list other adult relatives in the home such as grandparents, aunts, uncles, and/or cousins unless they are the primary caretaker(s) for the child or are financially responsible for the child.
- Be sure to specify the relationship of family members to the **child**.
- Also include the social security numbers for each family member listed on the application.
- Please indicate if the child you are applying for is a **foster child** on the application.
- If this is a foster child, please include the appropriate legal documentation (**DHS 1591B form and DSSH 1508 form**).
- Parent(s) or Guardian(s) must sign and date application form. In (2) parent households, both parents must sign.

BIRTH CERTIFICATE

- Send a copy **ONLY** for the child who is applying for tuition assistance.
- The Birth Certificate needs to be issued from the Department of Health, or other state's vital statistics agency if the child was not born in Hawaii. Please contact the Department of Health at 586-4533 to request a Hawaii birth certificate.

SOCIAL SECURITY CARDS*

- Send a copy for **EVERYONE** listed in the Family Information section of the application.
- If you need to request a card, please call the Social Security Administration at 1-800-772-1213.
- **The provision of a social security number is strictly voluntary. Failure to provide this information will not affect the application process or the amount of benefits you will receive. The use of social security numbers will be for agency use only as an internal identifier.*

PAY STUBS

- Send copies of pay stubs covering (pay dates for) the last **TWO CONSECUTIVE MONTHS** (or at least (8) consecutive weeks, and pay stubs must show the respective pay dates and pay periods) for **ALL** listed on the application
- If you started a new job a letter from your employer, specifying start date, hourly wage, hours worked per week, pay periods and your gross monthly earnings will be accepted.
- Gross monthly income will be used to determine eligibility.

IF APPLICABLE:

SPECIAL POPULATIONS PRIORITY REFERRAL FORM

- If applicable, the **Special Populations Priority Referral Form** must be completed by a professional familiar with your child and/or the family situation, such as a pediatrician, public health nurse, social worker, counselor or therapist.
- Your child **will not** be considered for a Special Populations Priority **without** a completed **Special Populations Priority Referral Form**.

SELF EMPLOYMENT (contact PATCH POD at Oahu: (808) 791-2130 or Toll Free: 1-800-746-5620 for more information and to be mailed the required forms

- Send a copy of your General Excise Tax License.
- If you have business expenses, copies of receipts **must** be submitted to determine eligibility.

OTHER DOCUMENTS

- Send verification of State of Hawaii financial assistance, Social Security benefits, SSI, Unemployment insurance benefits, Veteran's benefits, workers' compensation, child support and/or alimony, Temporary Disability Insurance (TDI).

Thank you for your interest in the Preschool Open Doors Program. Please **complete, sign, and mail/fax/email** the enclosed **Preschool Open Doors Application** with **ALL** required documents to:

Preschool Open Doors
PATCH – Attn. Applications Department
560 N. Nimitz Hwy, Ste. 218
Honolulu, HI 96817
or fax to (808) 694-3066
or email: PODAdmin@patch-hi.org



Mail to: PATCH – POD
560 N. Nimitz Hwy., Ste. 218
Honolulu, HI 96817
FAX: (808) 694-3066 or Email: PODAdmin@patch-hi.org

**PRESCHOOL OPEN DOORS
APPLICATION**

School Year 2020-2021

Parent/Guardian: _____
Last First M.I.

Co-Parent/Co-Guardian: _____
Last First M.I.

Home Address: _____
No. & Street City Island Zip Code

Mailing Address: _____
(If different from above) No. & Street or P.O. Box City Island Zip Code

Telephone Numbers: _____
Home Work Other

Primary Language Spoken: _____ Interpreter Services Needed? YES NO
*Complete and return attached DHS 5000 form

Email: _____

CHILD INFORMATION: Complete information on the child for whom you are applying:

Child's Name: _____ Child's Date of Birth: _____
Last First Middle Month Day Year

Is the child that you are applying for a foster child? No Yes **If yes, attach the forms DHS 1591B & DSSH 1508.**
DHS 1591B "Certificate of Approval of Foster Boarding Home" and DSSH 1508 "Agreement between DHS and Foster/Resource Parent"

FAMILY INFORMATION Provide the following information for each family member now living in your home including the Parent/Guardian listed above and the child you are applying for. **Do not** list grandparents, aunts, uncles, dependent children 18 years or older, and/or cousins, unless you are the primary caretaker(s) for the child.

FULL NAME			RELATIONSHIP TO CHILD	SEX (M or F)	BIRTHDATE	MARITAL STATUS	SOCIAL SECURITY NUMBER
LAST	FIRST	MIDDLE INITIAL					
			____ Parent ____ Guardian			____ Married ____ Divorced ____ Separated ____ Single	
			____ Parent ____ Guardian			____ Married ____ Divorced ____ Separated ____ Single	

List any additional household members on another sheet of paper and attach it to this application.

Total Family Size (Please only count those listed above and on any attachments): _____

SPECIAL POPULATIONS PRIORITY REFERRAL If your child has special needs, has environmental risk factors, is homeless, or has limited English-proficiency, a Special Populations Priority Referral Form must be completed. Your child will not be considered for a Special Populations Priority without a completed Special Populations Priority Referral Form.

FAMILY INCOME: Write the amount of each parent/guardian's monthly income in the boxes in the next section under "Source of Income"

Please provide 2 calendar months' worth (e.g. 8 weeks) of supporting documentation for **ALL** sources of income.

Parent/Guardian #1

Parent/Guardian #2

Source of Income

Name: _____

Name: _____

Amount Per Month

Amount Per Month

Wages/Salaries (before deductions) Pay stubs from employers must show the gross income earned		Pay Periods: <input type="checkbox"/> Weekly (once per week) <input type="checkbox"/> Bi Weekly (every other week) <input type="checkbox"/> Semi Monthly (two times per month) <input type="checkbox"/> Monthly (one time per month)		Pay Periods: <input type="checkbox"/> Weekly (once per week) <input type="checkbox"/> Bi Weekly (every other week) <input type="checkbox"/> Semi Monthly (two times per month) <input type="checkbox"/> Monthly (one time per month)
DHS Financial Assistance		Frequency received: <input type="checkbox"/> Monthly (one time per month)		Frequency received: <input type="checkbox"/> Monthly (one time per month)
Net Income from Self-Employment*		<i>CONTACT PRESCHOOL OPEN DOORS FOR FORMS NEEDED and SUBMITTING INCOME VERIFICATION</i>		<i>CONTACT PRESCHOOL OPEN DOORS FOR FORMS NEEDED and SUBMITTING INCOME VERIFICATION</i>
Child Support/Alimony		Frequency received: <input type="checkbox"/> Monthly (one time per month) <input type="checkbox"/> Other (explain how often)		Frequency received: <input type="checkbox"/> Monthly (one time per month) <input type="checkbox"/> Other (explain how often)
Social Security/SSI Benefits		Frequency received: <input type="checkbox"/> Monthly (one time per month) <input type="checkbox"/> Other (explain how often)		Frequency received: <input type="checkbox"/> Monthly (one time per month) <input type="checkbox"/> Other (explain how often)
Unemployment Insurance		Frequency received: <input type="checkbox"/> Bi Weekly (every other week)		Frequency received: <input type="checkbox"/> Bi Weekly (every other week)
Worker Comp/ TDI		Frequency received: <input type="checkbox"/> Weekly (once per week) <input type="checkbox"/> Bi Weekly (every other week) <input type="checkbox"/> Semi Monthly (two times per month) <input type="checkbox"/> Monthly (one time per month)		Frequency received: <input type="checkbox"/> Weekly (once per week) <input type="checkbox"/> Bi Weekly (every other week) <input type="checkbox"/> Semi Monthly (two times per month) <input type="checkbox"/> Monthly (one time per month)
Veterans Benefits		Frequency received: <input type="checkbox"/> Monthly (one time per month)		Frequency received: <input type="checkbox"/> Monthly (one time per month)
Other (identify source)		Frequency received: <input type="checkbox"/> Weekly (once per week) <input type="checkbox"/> Bi Weekly (every other week) <input type="checkbox"/> Semi Monthly (two times per month) <input type="checkbox"/> Monthly (one time per month)		Frequency received: <input type="checkbox"/> Weekly (once per week) <input type="checkbox"/> Bi Weekly (every other week) <input type="checkbox"/> Semi Monthly (two times per month) <input type="checkbox"/> Monthly (one time per month)
Total income per parent/guardian:				
Total income from other household members (and identify source):				

Total Monthly Income for **ALL** household members \$ _____

VERIFICATION SIGNATURE(S):

I hereby certify that all the information contained on this form is true and correct to the best of my knowledge. I submit this application with the understanding that I will give any additional information which may be needed and will allow the Department to verify my statements either with me or through other sources as necessary. I fully understand and accept my responsibility to report changes in my situation including changes in my child care within 10 calendar days. Furthermore, I understand that if I fail to report changes and receive assistance to which I am not entitled, the amount of overpayment will be collected from me, and I may be prosecuted for fraud.

ELECTRONIC BENEFITS TRANSFER (EBT): I am responsible to report lost or stolen EBT cards immediately, or a misdispensement occurrence, by calling the EBT toll-free customer service telephone number. I understand that there will be no replacement of any benefits accessed with an EBT card prior to the card being reported lost or stolen or the report of the misdispensement occurrence. I am responsible to report immediately any changes in the status of my alternate payee. I understand there will be no replacement of any benefits accessed by alternate payees or any other individuals using an EBT card and a valid PIN. I understand that child care payments are included in DHS "cash assistance household" accounts, and that child care benefits not withdrawn from my EBT account within ninety (90) days will be returned to the State. I understand that child care benefits that are returned to the State may be used to offset any outstanding overpayments that are owed by my household. (HAR §§17-799-21, 17-681-51, 17-681-52, and 17-681-56).

I understand that I have a right to request a case record review and administrative appeal if I do not agree with the Department's denial of my application for services.

Applicant Signature: _____ **Date:** _____

Co-applicant Signature: _____ **Date:** _____

(Signatures are REQUIRED from each parent/guardian living in the home and responsible for the child.)



**PRESCHOOL OPEN DOORS
SPECIAL POPULATIONS PRIORITY REFERRAL**

A. Family/Child Information (To be completed by parent):

Child's Name: _____ Child's Date of Birth: ____/____/____
Last Middle First Month Day Year
Parent/Guardian Name: _____
Last Middle First
Mailing Address: _____
No. & Street or P.O. Box City Zip Code
Telephone Numbers: _____
Home Work Other

B. Special Populations category(ies) the child qualifies for (To be completed by referring professional):

In order for a child to be determined as "Special Populations" Priority for Preschool Open Doors, **at least one section** must be completed by a professional providing services and/or familiar with the child and family, such as a pediatrician, public health nurse, social worker, counselor, therapist, Healthy Start representative, or Department of Health (DOH) Children's Team.

1. **"Special Needs"** – the child has a physical, developmental, behavioral, or an emotional health condition that is outside the normal range.

2. **"Environmental Risk"**

must check ONE of the following conditions:

- Parental age – less than 16 years
- Any existing physical, developmental, emotional, or psychiatric disability in a primary caretaker
- Abuse or any legal or illegal substance by a primary caretaker
- Child abuse and neglect of target child or sibling

-OR-

must check TWO of the following conditions:

- Single Parent
- Incarceration of a primary caretaker
- Birthweight: (Less than 5.5 lbs.)
- Parental age: 16-18 years and less than high school education
- Economically disadvantaged family (less than 100% Federal Poverty Income Guidelines for Hawaii)
- Presence of physical, developmental, emotional, or psychiatric disability in a sibling or other family member in home

3. **"Homeless"** – the child's family must be participating in or enrolling in a program for homeless services.

4. **"Limited English Proficiency (LEP)"**

The child and family or adults caring for the child must have limited English proficiency. Indicate the degree of proficiency.

Primary language(s) spoken at home: _____

Parent(s) English proficiency: Fair____ Poor____ None at All____

Child's English proficiency: Fair____ Poor____ None at All____

C. Certification of Special Populations category(ies) the child qualifies for (To be completed by referring professional):

Description of child's Special Populations needs (details of confidential family information may be omitted):

I hereby certify that I am providing services and/or am familiar with the child and family, and in my professional capacity, I have determined that the child and family meet the above Special Populations category(ies) I have indicated.

Person making referral: _____ Title: _____

Agency/Office: _____ Phone: _____

Address: _____

Signature: _____ Date: _____

For Preschool Open Doors staff only:
DHS Interpreter Services requested: ___ YES ___ NO DHS 5000 form Dated: _____ is attached.

OFFER AND ACCEPTANCE OR WAIVER OF FREE INTERPRETER SERVICES

Case Name: _____ Case Number: _____

Interpreter Needed For: _____
(Name)

Worker: _____ Unit: _____

Phone: _____ Fax: _____

The Department of Human Services (DHS) has offered an interpreter at no cost to me, if English is not my primary language.

1. ENGLISH is my primary language:	<input type="checkbox"/> YES*	<input type="checkbox"/> NO
*Sign and date below.		
2. <input type="checkbox"/> I do not need an interpreter. If you do not need an interpreter go to part 4 and sign below:		
<input type="checkbox"/> I need an interpreter for the following language: _____		
If you need an interpreter, go to part 3, and check the box that applies to you.		
3. <input type="checkbox"/> I want DHS to provide an interpreter at no cost to me.		
<input type="checkbox"/> I do not want an interpreter provided by DHS, and I will provide my own.		
<ul style="list-style-type: none"> • I understand that DHS may secure an independent interpreter to observe my interpreter to ensure the accuracy of the communications. • I understand that the use of family or friends as interpreters may not be the most effective way to help me access the benefits and services that DHS provides. • I understand that DHS does not recommend the use of family members or friends as interpreters and prohibits the use of minors (no one under age 18) as interpreters. • I understand that if I do not want interpreter services at this time, I have the right to change my mind in the future and have DHS provide free interpreter services at that time or bring an interpreter of my choice. 		
4. I have read and understand the information on this form. If I have questions or concerns, I can contact the worker listed above.		
Print Name: _____	Phone: _____	
Signature: _____	Date: _____	