Edina Early Learning Center
Financial Assistance Application

TODAY'S DATE:

CHILD INFORMATION - All information will be held confidential			
Child's Name:	Date of Birth (DOB):	Gender: ☐M ☐F	Primary Language:
Address:	City:	State:	Zip:
Is your child enrolled in any other preschool? ☐Y ☐N	Edina School District (ISD 273) Resident: ☐Y ☐N		Sibling care needed? ☐Y ☐N
Racial Background: ☐American Indian or Alaska Native ☐Asian or Pacific Islander ☐Black, not of Hispanic Origin ☐Hispanic ☐White, not of Hispanic origin			

ADDITIONAL CHILDREN IN HOUSEHOLD:

Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

HOUSEHOLD SIZE: Number of Children_____+ Number of Parent/Guardians_____+ Other household members_____= Total Family Size _____

PARENT/GUARDIAN INFORMATION				
ADULT 1:	First name:	Last name:	Relationship:	Living with child: ☐Y ☐N
	Occupation:	Email:	Home Phone:	Cell Phone:
ADULT 2:	First name:	Last name:	Relationship:	Living with child: ☐Y ☐N
	Occupation:	Email:	Home Phone:	Cell Phone:
ADULT 3:	First name:	Last name:	Relationship:	Living with child: ☐Y ☐N
	Occupation:	Email:	Home Phone:	Cell Phone:

HOUSEHOLD INCOME INFORMATION - Write in each income and how often it is received: weekly, bi-weekly, twice per month, monthly, or yearly.

	Gross Annual Income before deductions	Public Assistance, Child Support, Alimony, Unemployment	Pension, Social Security, Retirement, Permanent Disability	Other income, including net self-employment	TOTAL
ADULT 1	$ per	$ per	$ per	$ per	$
ADULT 2	$ per	$ per	$ per	$ per	$
ADULT 3	$ per	$ per	$ per	$ per	$
				TOTAL YEARLY INCOME:	**$**

Do you receive/qualify for: ☐SNAP ☐CCAP ☐FRLP ☐MFIP ☐State Scholarship

CONTINUES ON REVERSE ➔

OFFICE USE ONLY	Class #:	Start Date:	☐Monthly ☐Semester
	TOTAL FINANCIAL AID: $	**TOTAL BALANCE DUE: $**	**MONTHLY/SEMESTER PAYMENT: $**
	ECFE AID: $ LSP AID: $		

PARENT CHECKLIST ALL INFORMATION WILL BE HELD CONFIDENTIAL

FAMILY - PLEASE CHECK ALL THAT APPLY TO YOUR FAMILY SITUATION	
☐Y ☐N	Family speaks English at home
☐Y ☐N	Parent/guardian has a GED or high school diploma
☐Y ☐N	Family has moved two or more times in the past year
☐Y ☐N	Single-parent household
☐Y ☐N	Parent has physical impairment (hearing, sight, etc...)
☐Y ☐N	Older siblings who have had difficulty with school or are in special education
☐Y ☐N	Family has experienced abuse, neglect or family violence
☐Y ☐N	Family stress during past year (unemployment, divorce, death, incarcerations, etc...)
☐Y ☐N	Mother below age 18 at birth of first child
☐Y ☐N	Family qualifies for free or reduced lunch program and/or community services based on income
CHILD - PLEASE CHECK ALL THAT APPLY TO YOUR CHILD	
☐Y ☐N	Child has had previous preschool, nursery school or day care experience
☐Y ☐N	Mild to moderate delays in speech emotional development or cognitive development skills
☐Y ☐N	Child has physical, hearing or vision problems
☐Y ☐N	Medical problems (frequent or chronic illness)
☐Y ☐N	Child's behavior is a problem at home
☐Y ☐N	Foster child or in "out-of-home" placement
☐Y ☐N	Has completed early childhood developmental screening Location:

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DEVELOPMENT? PLEASE DESCRIBE BELOW

I certify that all the information provided on this application is true and correct. Because state funds are used on the basis of this information, I understand that school and state officials may verify this information.

Printed Name: _____ Signature: _____ Date: _____

PLEASE RETURN TO:

BY MAIL: Edina Early Learning Center | 5701 Normandale Road | Edina, MN 55424
BY FAX: 952-848-4239 For questions, please call 952-848-3908 or visit
www.edinaschools.org/earlylearningcenter