

Ohio Department of Job and Family Services  
**APPLICATION FOR EARLY LEARNING INITIATIVE (ELI) BENEFITS**

**Early Learning Initiative (ELI) benefits are provided in educational programs that help preschool children, who are at least three years old, enter kindergarten ready for success. When you have completed this application please turn it in to the County Department of Job and Family Services (CDJFS) in the county where you live.**

**P L E A S E   P R I N T**

Name of Parent/Caretaker  Maiden or Previous Married Name	<b>Date of Birth</b>  <input type="checkbox"/> Male  <input type="checkbox"/> Female	Social Security Number (optional*)    * Used only for the purpose of administering the ELI program.	<b>Race/Ethnicity - Check Y or N for each:</b> <input type="checkbox"/> Y <input type="checkbox"/> N African American/Black <input type="checkbox"/> Y <input type="checkbox"/> N Alaskan Native/ American Indian <input type="checkbox"/> Y <input type="checkbox"/> N Asian <input type="checkbox"/> Y <input type="checkbox"/> N Native Hawaiian/Pacific Islander <input type="checkbox"/> Y <input type="checkbox"/> N White <input type="checkbox"/> Y <input type="checkbox"/> N Hispanic/Latino
Name of Child Who Will Attend ELI	<b>Date of Birth</b>  <input type="checkbox"/> Male  <input type="checkbox"/> Female	Social Security Number (required)	<b>Race/Ethnicity - Check Y or N for each:</b> <input type="checkbox"/> Y <input type="checkbox"/> N African American/Black <input type="checkbox"/> Y <input type="checkbox"/> N Alaskan Native/ American Indian <input type="checkbox"/> Y <input type="checkbox"/> N Asian <input type="checkbox"/> Y <input type="checkbox"/> N Native Hawaiian/Pacific Islander <input type="checkbox"/> Y <input type="checkbox"/> N White <input type="checkbox"/> Y <input type="checkbox"/> N Hispanic/Latino
Name of Child Who Will Attend ELI	<b>Date of Birth</b>  <input type="checkbox"/> Male  <input type="checkbox"/> Female	Social Security Number (required)	<b>Race/Ethnicity - Check Y or N for each:</b> <input type="checkbox"/> Y <input type="checkbox"/> N African American/Black <input type="checkbox"/> Y <input type="checkbox"/> N Alaskan Native/ American Indian <input type="checkbox"/> Y <input type="checkbox"/> N Asian <input type="checkbox"/> Y <input type="checkbox"/> N Native Hawaiian/Pacific Islander <input type="checkbox"/> Y <input type="checkbox"/> N White <input type="checkbox"/> Y <input type="checkbox"/> N Hispanic/Latino
Name of Child Who Will Attend ELI	<b>Date of Birth</b>  <input type="checkbox"/> Male  <input type="checkbox"/> Female	Social Security Number (required)	<b>Race/Ethnicity - Check Y or N for each:</b> <input type="checkbox"/> Y <input type="checkbox"/> N African American/Black <input type="checkbox"/> Y <input type="checkbox"/> N Alaskan Native/ American Indian <input type="checkbox"/> Y <input type="checkbox"/> N Asian <input type="checkbox"/> Y <input type="checkbox"/> N Native Hawaiian/Pacific Islander <input type="checkbox"/> Y <input type="checkbox"/> N White <input type="checkbox"/> Y <input type="checkbox"/> N Hispanic/Latino
Street Address		Home Phone Number (       ) Cell Phone Number (       )	
City	Zip Code	County	
Mailing Address (if different from above)	City	Zip Code	County

Name of ELI Provider Requested			
Street Address			
City	State OH	Zip Code	Phone Number

**You must report to the county if you change ELI providers.**

**List below the names of all family members living in your home and all sources of income, both earnings from employment and any other unearned income, such as social security, unemployment benefits, pension benefits or OWF cash assistance. You will need to provide proof of all sources of income. You may have a copayment for ELI benefits. If you have a copayment, it must be paid to the ELI provider each month.**

<b>Name</b>	Relationship to Child	Date of Birth
Employer Name and Address	Amount of Monthly Income \$	How often is this income received?
<b>Name</b>	Relationship to Child	Date of Birth
Employer Name and Address	Amount of Monthly Income \$	How often is this income received?
<b>Name</b>	Relationship to Child	Date of Birth
Employer Name and Address	Amount of Monthly Income \$	How often is this income received?
<b>Name</b>	Relationship to Child	Date of Birth
Employer Name and Address	Amount of Monthly Income \$	How often is this income received?
<b>Name</b>	Relationship to Child	Date of Birth
Employer Name and Address	Amount of Monthly Income \$	How often is this income received?
<b>Name</b>	Relationship to Child	Date of Birth
Employer Name and Address	Amount of Monthly Income \$	How often is this income received?

What is your preferred language?

Do you receive child support for any child(ren)?  Yes  No If yes, please name the child(ren) and show the monthly amount of child support:

_____	\$ _____
_____	\$ _____
_____	\$ _____

Do you pay child support for any child(ren)?  Yes  No If yes, you will be asked to verify the amount of this payment.

Do you receive subsidized child care benefits for any child(ren)?  Yes  No If yes, please name the child(ren):

_____	_____
_____	_____

## YOUR RIGHTS AND RESPONSIBILITIES

### Please read the following information carefully:

Eligibility for Early Learning Initiative (ELI) benefits shall be determined at the time a completed JFS 01155 Application for Early Learning (ELI) Benefits is submitted to the county department of Job and Family Services (CDJFS) in the county where you live. Eligibility for ELI will be determined within 15 calendar days from the date the CDJFS receives your completed application. You must complete the application process and submit all supporting documentation within 15 calendar days from the date you submit your application to the county or your application shall be denied. If your child is eligible for ELI, payment for benefits may begin on the date the CDJFS receives your application and can last as long as 12 months. At the end of 12 months, your eligibility for ELI benefits will be redetermined.

You are responsible for giving complete and accurate information about yourself, all family members in your home and all sources of income. You must submit this written application and all necessary documentation of income. Sources of income include but are not limited to: salary, wages, tips, commissions, bonuses, retirement benefits, social security benefits, unemployment compensation, workers' compensation, interest, dividends, alimony, child support, Ohio Works First (OWF) cash assistance and receipts from self-employment.

You may be required to pay a monthly copayment to the ELI provider. This copayment is based on your monthly income. If your income is reduced, please report this to the CDJFS so that your copayment may be reviewed. If the copayment is reduced, the reduction will take place in the next copayment calendar month. As a condition of eligibility, **you must pay your required copayment** to the ELI provider. Failure to pay the copayment may result in the termination of ELI benefits.

You must **sign the attendance log at the provider's location** to verify your child's attendance at the ELI program.

Failure to repay an ELI overpayment caused by your error or to enter into or comply with an agreement to repay an overpayment caused by your error, will result in the termination of ELI benefits. Ineligibility for ELI benefits will continue as long as: 1) you owe repayment of an ELI overpayment; or 2) you fail to enter into or comply with an agreement to repay an ELI overpayment.

You have a right to a conference with the CDJFS if you disagree with any part of the eligibility process. If you are not satisfied with the result of your county conference, you can still have a state hearing. You will be given a copy of the JFS 04059 "Explanation of State Hearing Procedures" with this application. Read this form carefully to understand your hearing rights and the hearing process.

You have a right to a state hearing before the Ohio Department of Job and Family Services (ODJFS) if: 1) your application is denied but you believe you are eligible; 2) you are not told in writing within 15 days of the date your completed application is filed with the CDJFS whether or not you are eligible for ELI benefits; 3) you do not agree with the type or amount of your benefits; 4) you are not told in writing the reason your benefits are to change; 5) you disagree with any action taken by the county. For a complete explanation of your right to a state hearing and the way to request a state hearing, see the JFS 04059 that you received with this application.

### **You will need to sign below that you have read and understand these rights and responsibilities.**

I understand that my application for ELI will be considered without regard to race, color, ancestry, sex, age, handicap, religion or national origin. To the best of my knowledge and belief the answers on this application are complete and correct. I understand the law provides penalty of fine or imprisonment, or both, for anyone convicted of accepting benefits for which he or she is not eligible. I state under penalty of perjury that all information is true and complete to the best of my knowledge.

I received a copy of and I have read my rights and responsibilities and I understand them. I agree to fulfill my responsibilities as described. I give my consent to the agency to make whatever contacts are necessary to determine my eligibility for ELI and to verify the information I have given in this application. I understand that I will receive a complete explanation regarding the requirements for determining eligibility, the reasons why I may not be eligible, my right to a state hearing, my responsibility for reporting changes to the CDJFS and the penalty, including possible civil action or criminal prosecution, for the intentional withholding or falsification of information or misuse of ELI benefits.

To file a discrimination complaint, write or call the Ohio Department of Job and Family Services at ODJFS, Bureau of Civil Rights, Director, Office of Civil Rights, 30 E. Broad St., 37th Floor, Room 506-F Columbus, OH 43215, (614) 644-2703 (voice), 1-866-227-6353 (voice - toll free), Fax: (614) 752-6381. You may also write or call the federal department of Health and Human Services at HHS, Office of Civil Rights, 200 Independence Ave. SW, Washington, D.C. 20201, (202) 619-0403 (voice), 1-866-221-6700 (TTY), (202) 619-3257 (TDD).

**Your signature below allows the CDJFS to release information about this application, the documentation you submit and your eligibility for ELI, and you give your consent to the CDJFS to make the contacts necessary to determine your eligibility and to verify the information given in this application.**

Signature of Caretaker	Date
Signature of Person Who Helped Complete This Application	Date