EARLY LEARNING COALITION
OF POLK COUNTY
*Heart of Education*

# MEMORANDUM OF UNDERSTANDING

Between the **Early Learning Coalition of Polk County (Coalition) and** the **Homeless Coalition of Polk County (Homeless Coalition)** agreed to enter into a memorandum of understanding of mutual benefit. This agreement is to be effective July 1, 2022 through June 30, 2023.

**Purpose:**
Homelessness influences every facet of children's lives, inhibiting their physical, emotional, cognitive, social, and behavioral development. Signing parties understand and recognize the importance and value of teamwork to offer prioritized child care services for parents with children in shelter care.

This agreement is for the coordination of child care services for homeless children in Polk County and whereby the Homeless Coalition's continuum of care agencies (Exhibit F) will refer families who may need child care services provided by the Coalition.

Florida Statue generally defines homelessness as an individual or family who lacks a fixed, regular and adequate nighttime residence and includes an individual who:

a. Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
b. Is living in a motel, hotel, travel trailer park, or camping ground due to lack of alternative adequate accommodations;
c. Is living in an emergency or transitional shelter;
d. Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
e. Is living in a car, park, public space, abandoned building, bus or train station, or similar setting; or
f. Is a migratory individual who qualifies as homeless because he or she is living in circumstances described in sections (a) – (e) (s. 420.621 (5) F.S.)

**General Provisions:**
Services may be provided to a child or a family under the Homeless Coalition's supervision or while housed in a contracting homeless shelter. Eligibility consideration is not solely dependent on family income or work requirements; a documented referral must be provided though the Homeless Coalition.

The initial authorization referral may be validated in sixty (60) day increments on a case-by-case basis not to exceed six (6) months.

**Responsibilities:**

**Continuum of Care Agencies**
The Continuum of Care Agencies will be responsible for:

1. Initiating the referral by completing all required information on the forms listed below and submitting them to the Coalition for services. The Case Manager may request the renewal authorization of School Readiness services for the referred family in increments of 6 months or less. All referrals are valid for 10 calendar days from issuance.

    a. Division of Early Learning's (DEL) referral form (Exhibit A)
    b. Fee Reduction/ Waiver Request Form (Exhibit C)
    c. At-Risk Child Care Checklist (Exhibit D)
    d. Have parent create a Family Portal account at https://familyservices.floridaearlylearning.com/
    e. Submit proof of employment with four weeks of current pay stubs or Verification of Employment (if applicable) upload to family portal (Exhibit E)
    f. Parent must log back in to Family Portal account and accept enrollment once notified by Coalition Staff.

2. Informing families being referred of documentation requirements, i.e., birth certificates for all children in the household (State issued), proof of income/employment, and picture ID; services will not be denied if information is not readily available.
3. Notifying the Coalition when the family is no longer participating in the program or when the family no longer needs the services by completing FOEL's Notice of Change form (Exhibit B) and submitting it to the Coalition.
4. Offering feedback on referral issues to benefit Coalition staff.
5. Maintaining a case record documenting the status of the case.

**Coalition**
The Coalition will be responsible for:

1. Providing resources and referral service to Homeless families.
2. Providing services within timeframes as outlined in the Grant Agreement with DEL.
3. Notifying the Continuum of Care Agencies when the Coalition has enrolled child(ren) into care.
4. Providing a trained and dedicated specialist to serve as liaison between the agencies.
5. Offering feedback on referral issues to benefit Homeless families.
6. Maintaining a case record documenting the status of the case.

**Points of Contact:**

The agency director will be the point of contact for the Homeless Coalition and the Contract Manager will be the point of contact for the Early Learning Coalition.

ContractManager@elcpolk.org phone: (863) 733-9064 x. 307 Fax: (863) 733-9081

**Confidentiality Notices:**

Pursuant to section 1002.97(1)-(2), F.S., the individual records, held by the Coalition or DEL, of children enrolled in the School Readiness program are confidential and are exempt from public records statutes (section 119(1) and 24(a), Article 1 of the State Constitution). Records include assessment date, health data, records of teacher observation and personal identifying information. A parent has the right to inspect and review the individual School Readiness program records of his or her child and to obtain a copy of the records.

In accordance with section 90.5036(1)(d)&(2), F.S., communication between a domestic violence advocate and a victim is confidential if it relates to the incident of domestic violence for which the victim is seeking assistance and if it is not intended to be disclosed to third persons other than those persons present to further the interest of the victim in the consultation, assessment or interview. A victim has the privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made by the victim to a domestic violence advocate or any record made in the course of advising, counseling or assisting the victim.

**Reviewing and Implementing MOU:**

Any and all changes to the Memorandum of Understanding shall be in writing and signed by both parties before becoming effective, agreed to and executed.

In witness thereof, the parties have caused this Memorandum of Understanding to be executed by their duly authorized officials.

**Early Learning Coalition of Polk County**

DocuSigned by:
Marc Hutek
8DC8EF5EF5F54CF...

BY: _____

Dr. Marc Hutek
Chief Executive Officer
07/01/2022

DATE: _____

**Homeless Coalition of Polk County**

DocuSigned by:
Bridget Engleman
638ED5BEEF084A5...

BY: _____

Bridget Engleman
Executive Director
07/01/2022

DATE: _____

# Exhibit A

## Child Care Application and Authorization Form
## Certified Domestic Violence Center or Designated Homeless Program

**THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE**

| | |
|---|---|
| **Authorization Type:** | ☐ INITIAL AUTHORIZATION<br>☐ REDETERMINATION |

| FROM: (Print Worker Name) | Phone Number |
|---|---|
| Organization Name | |
| Mailing Address, City, Zip Code | |

### SECTION A: FAMILY INFORMATION

| Parent/Guardian #1 Social Security No. (optional) | (Print) Last Name | First Name | MI | Date of Birth | Gender | Race |
|---|---|---|---|---|---|---|
| | | | | | | |

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

| Parent/Guardian #2 Social Security No. (optional) | (Print) Last Name | First Name | MI | Date of Birth | Gender | Race |
|---|---|---|---|---|---|---|
| | | | | | | |

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

| Mailing Address: | City | State | Zip Code | Contact Phone No. |
|---|---|---|---|---|
| | | | | |

### CHILD INFORMATION

| Child Social Security No. (optional) | (Print) Last Name | First Name | MI | Date of Birth | Gender | Race |
|---|---|---|---|---|---|---|
| | | | | | | |
| Child Social Security No. (optional) | (Print) Last Name | First Name | MI | Date of Birth | Gender | Race |
| | | | | | | |
| Child Social Security No. (optional) | (Print) Last Name | First Name | MI | Date of Birth | Gender | Race |
| | | | | | | |

**Note:** Use the CLARIFYING COMMENTS section if there are more than three children for one referral.

### SECTION B: ELIGIBILITY

| | | |
|---|---|---|
| **At-Risk Status:**<br>**Please select one of the reasons for purpose of care:** | ☐ Designated Homeless Program Participant | ☐ Certified Domestic Violence Center Resident |
| **Verification of the Following (with Documentation Attached):**<br>**For child(ren) needing care:** | ☐ U.S. Citizen or Qualified Alien<br>☐ Verification of Age | Comments: |

### SECTION C: AUTHORIZATION

**Hours:** Child care service is authorized for this client for approved activity(ies) not to exceed a total of _____ hours per week.
This total includes _____ hours per week for reasonable transportation time.

**Dates:** Child Care Authorization From _____/_____/_____ through _____/_____/_____.
(3 months or less for domestic violence center resident and 6 months or less for homeless program participant)

### SECTION D: AUTHORIZING SIGNATURES

**I hereby certify that the information provided above is correct.**

| | |
|---|---|
| **Applicant Signature:** _____ | **Date:** _____ |
| **Worker Authorizing Referral Signature:** _____ | **Date:** _____ |
| **Coalition Staff: (Print)** _____ **Signature:** _____ | **Date:** _____ |

**Child Care Application and Authorization Form**
Form OEL-DV/HM 01, Part A (July 2013)

| Child Care Application and Authorization Form<br>Certified Domestic Violence Center or Designated Homeless Program |
| --- |
| THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE |

| SECTION E: CLARIFYING COMMENTS (IF APPLICABLE) |
| --- |
| |

**Child Care Application and Authorization Form**
Form OEL-DV/HM 01, Part A (July 2013)

# Instructions for Child Care Application and Authorization Form
# Certified Domestic Violence Centers or Designated Homeless Program

**THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE**

## INTRODUCTION

This form is intended to be the single referral and authorization form for child care services provided by the School Readiness child care program for families who are residents in a certified domestic violence center or who are participating in a designated homeless program. It is designed to be used by staff of the Department of Children and Families (DCF)-certified domestic violence centers and DCF-designated lead agencies on homelessness.

## CHILD CARE APPLICATION AND AUTHORIZATION

The worker completing the form should indicate whether it is an initial authorization or a redetermination. The "FROM" section must clearly identify the program sending the referral and authorizing child care. The worker completing the form must also include the mailing address, city and zip code for the referring agency in this section.

## SECTION A: FAMILY INFORMATION

**Social Security No.:** Enter Parent/Guardian/Caregiver's Social Security Number (optional).

**Primary Parent :** Enter Primary Parent/Guardian/Caregiver's last and first name, date of birth, demographics and marital status.

**Secondary Parent:** Enter Secondary Parent/Guardian/Caregiver's last and first name, date of birth, demographics and marital status.

**Mailing Address:** Enter the family's mailing address and phone number(s) as appropriate.

**Child(ren):** For children authorized to receive care, enter the Social Security Number (optional), last and first name, date of birth and demographics. Use the CLARIFYING COMMENTS section if there are more than three children for one referral.

## SECTION B: ELIGIBILITY

**At-risk status:** This refers to the client's purpose for care. Check the appropriate box (only one box) for Designated Homeless Program Participant or Certified Domestic Violence Center Resident.

**Verification Documents:** Check the appropriate box if the worker has verified the child(ren)'s citizenship or child(ren)'s age and attached the applicable documentation to the referral.

Note – Information may also be collected by the coalition, as established in the Memorandum of Agreement.

**Comments:** Indicate additional comments pertaining to application information, if applicable.

## SECTION C: AUTHORIZATION

**Hours Authorized:** Indicate in the spaces provided the total hours per week that the worker has authorized child care based on the parent's prescribed program activities and the hours allotted for reasonable transportation time.

**Dates:** Indicate the starting and ending date for authorized child care period. The worker must send a redetermination authorization to the coalition prior to the end of the initial referral if the family remains eligible. Services for the referred families may be requested in increments of six months or less for homeless program participants and three months or less for **current resident**s in a certified domestic violence center.

## SECTION D: AUTHORIZING SIGNATURES

**Applicant Signature:** Applicant (if available) must sign and date in the space provided.

**Worker Authorizing Referral Signature:** Referring agency worker must sign and date the referral on the date of authorization. The referral is NOT VALID if it is not signed by the authorized representative.

**Coalition Staff:** A coalition staff person must print his or her name, sign and date the referral in the space provided. The date must reflect the date received. The coalition's staff must offer services to referred families within 10 calendar days from receipt of a valid referral in accordance with the Early Learning Grant Agreement.

## SECTION E: CLARIFYING COMMENTS

The worker may use this space of the application to indicate clarifying comments that are pertinent to the application information.

**Note** – The referring case manager must use the Notice of Change in Child Care Status form to inform the early learning coalition of the changes in the family's child care status. Changes may include termination of care for the family's failure to participate in the program or loss of purpose for care.

Instructions for **Child Care Application and Authorization Form**
Form OEL-DV/HM 01, Part B (July 2013)

# Exhibit B

## Notice of Change in Child Care Status Form
## Certified Domestic Violence Center or Designated Homeless Program

| TO: | Date Mailed: |
|---|---|
| Address: | |

### SECTION A: STATUS

| | | |
|---|---|---|
| Your child care status: | ☐ Is being terminated | ☐ Needs to be redetermined |
| Your last day of child care services will be: | | |

Due to the following reason:

| | | |
|---|---|---|
| ☐ | You are no longer eligible for child care because | |
| ☐ | You failed to provide the following information needed to verify your eligibility: | |
| | If you want your child care to continue, you must provide the item(s) above before your last day of services. | |
| ☐ | Your authorization period ends on the above date. To continue child care, contact: | |
| ☐ | Your continuation of child care services needs to be assessed. | |

### SECTION B: CHILD CARE SERVICES AFFECTED FOR THE FOLLOWING CHILDREN

| Child's Name | Date of Birth | SSN (optional) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

### SECTION C: NOTICE AUTHORIZED BY REFERRING AGENCY/WORKER INFORMATION

Agency

Mailing Address, City, Zip Code

Phone Number

Worker Authorizing Referral Name (print): _____

Worker Authorizing Referral Signature: _____ Date: _____

Copies sent to:
☐ Early Learning Coalition of _____
☐ Other _____

**Notice of Change in Child Care Status Form**
Form OEL-DV/HM 02, Part A, (July 2013)

# Instructions for Notice of Change in Child Care Status Form
# Certified Domestic Violence Center or Designated Homeless Program

**WHEN COMPLETING THE FORM, PLEASE PRINT CLEARLY**

## INTRODUCTION

This form is intended to be the Notice of Change in Child Care Status form for school readiness child care services for families currently residing in a certified domestic violence center or participating in a Department of Children and Families (DCF)-designated homeless program. It is designed to be used by staff of the DCF-certified domestic violence centers and DCF-designated lead agencies on homelessness.

The person completing the form should indicate the name and address to whom the agency must send the form.

| | |
|---|---|
| **TO:** | Enter client's name. |
| **Address:** | Enter client's mailing address. |
| **Date Mailed:** | Enter the date the form is completed and mailed. |

## SECTION A: STATUS

| | |
|---|---|
| **Terminated:** | Check box if the agency is terminating services for a current client. |
| **Redetermined:** | Check box if the agency needs to redetermine services for a current client. |
| | **Note** – Referring agencies will check either terminated or needs to be redetermined and send a copy to the early learning coalition and client. The early learning coalition will contact the child care provider and the client to inform them of the change in services. |
| **Date:** | Enter the last day of child care services. (Allow at least two weeks before terminating. However, in some instances the notice may be less than two weeks because the two week notice should not extend beyond the original authorization period.) |
| **Reason:** | Check the box **to the left of the statement** that applies to the client's situation. Fill in the blanks with the appropriate information. |

## SECTION B: CHILDREN'S INFORMATION

| | |
|---|---|
| **Child's Name:** | Enter name of child(ren) the action affects. |
| **Date of Birth:** | Enter child(ren)'s date of birth. |
| **SSN (optional):** | Enter child(ren)'s Social Security Number. |

## SECTION C: AGENCY/WORKER INFORMATION

| | |
|---|---|
| **Agency:** | Enter the referring agency's name. |
| **Mailing Address, City, Zip Code, Phone No.:** | Complete agency mailing address, city, zip code and telephone number in full. |
| **Worker's Information** | Enter agency worker's name and signature. |
| **Copies Sent To:** | Check appropriate boxes, and send to the individuals checked. Retain a copy for the agency's file. |

Instructions for **Notice of Change in Child Care Status Form**
Form OEL-DV/HM 02, Part B (July 2013)

EARLY LEARNING COALITION
OF POLK COUNTY

# Exhibit C

## Fee Reduction/Waiver Request Form

Client's Name _____ Client's SSN _____

The below listed child(ren) will be affected by this action for child care services:

| Child's Name | Child's DOB | Child's SSN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Reasons for a possible fee reduction/waiver per 6M-4.400(1) and (2)

- ☐ Child's parent/guardian is in prison
- ☐ Child's parent/guardian become incapacitated
- ☐ Homeless shelter/living arrangements
- ☐ Child's parent/guardian experience an emergency
- ☐ Child's parent/guardian negotiated a lower fee
- ☐ Child's parent/guardian are in residential treatment
- ☐ Death of child's parent/guardian
- ☐ Child's parent/guardian experience a natural disaster
- ☐ Child's parent/guardian become unemployed ≤ 90 days
- ☐ Child's parent/guardian participate in a parenting class

Referring Agency/PC Signature _____ Date _____

Agency/Work Unit _____ Phone Number _____

Address, Including City _____

FOR OFFICE USE ONLY

[ ] WAIVER

[ ] REDUCTION Period of Approval: _____

[ ] APPROVED Actual Fee: _____

[ ] DENIED Reduced/Waived fee: _____

COMMENTS: _____

# Exhibit D

EARLY LEARNING COALITION
OF POLK COUNTY

## AT-RISK CHILD CARE CHECKLIST

The following information **must** be received by the Coalition in order to ensure that the request for child care services is processed. Please initial the line next to each item to verify that the information has been provided. **Referral must be received and process by the Coalition prior to child(ren) starting at the child care provider. Please do not fax referrals directly to child care providers.**

**Name of Parent(s)/Guardian:** _____

**Email of Parent(s)/Guardian:** _____

**Name(s) of child(ren):** _____

___ **Type of Authorization** - Initial, Redetermination, or Transfer (Paid in full receipt needed)

___ **Complete name of referring worker, organization name, address, & contact number**

___ **Section A: Family/Child Information**
- Complete name of parent or guardian, SSN# (optional), date of birth, ethnicity / race, marital status. If two parent household information of other parent should be included
- Complete address including city, state, zip code, contact number
- Complete child name, SSN# (optional), date of birth, gender, and race for each child in family

___ **Section B: Eligibility**
- At-Risk status checked
- Verification of U.S. Citizen or Qualified Alien
- Verification of Age
- Comments (Fee waiver form if applicable)

___ **Section C: Authorization**
- Total hours of care needed per week
- Dates of authorization not to exceed 6 months

___ **Section D: Authorizing Signatures**
- Must have Signature of Referring Worker
- Must have parent/guardian signature

- Have parent create a Family Portal account at https://familyservices.floridaearlylearning.com/
- Submit proof of employment with four weeks of current pay stubs or Verification of Employment (VOE) (if applicable) with referral

**Please complete the following information (Please Print):**

Child Care Provider: _____
Provider Address: _____
Provider Phone Number: _____

Referring Worker Name: _____
Phone Number: _____ Email: _____

Supervisor Name: _____
Phone Number: _____ Email _____

Attn: Admin Assistance
Fax number 863-577-2469

# Exhibit E

EARLY LEARNING COALITION
OF POLK COUNTY

## Verification of Employment
## Or
## Loss of Employment

Date: _____

I, _____ give permission for my employer to release the following information to Early Learning Coalition of Polk County for the purpose of determining my eligibility for childcare assistance.

_____
Parent/Guardian Signature

**Section I – General Information**

Name of Employee: _____

Address of Employee: _____

Job title: _____ Type of work performed: _____

Number of hours/week: _____ Number of days/week: _____

How often is/was employee paid: ____ day ____ week ____ bi-weekly ____ monthly

Rate of pay: $_____ per _____ (hr/day/wk/etc.) Other_____

Date current employment began: _____ Date previously employed: _____

Does/did employee receive tips? _____ (if yes, please show tips in Section II)

**Section II – Record of Pay Received**

List the gross amount and dates of checks or cash which were paid for the last 4 weeks in the space below.

| Pay Period Ending | Date Pay Received | Gross Earnings | Number of hours worked | Rate of pay | Number of OT hours | Rate of pay for OT | Tips |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Page 1 of 2

Revised 4/1/2020

EARLY LEARNING COALITION
OF POLK COUNTY

# Verification of Employment
# Or
# Loss of Employment

If hours or rate of pay has varied in Section II, please state why. _____

_____

_____

_____

**Section III – Loss of Employment**

Date employment ended: _____

***Please list last 4 weeks of pay in Section II.***

**Section IV – Employer Information**

I certify that the information given in this form is true and correct to the best of my knowledge. I also acknowledge that the purposeful giving of false information is a prosecutable offense.

_____ _____
Signature of Employer Printed Name of Employer

_____ _____
Employer's Title Employer's Telephone Number

_____
Employer Email:

_____
Name and Address of Employer

_____
Date Completed

Return completed form to: Early Learning Coalition of Polk County

Attention: _____

Revised 4/1/2020

# Exhibit F

## Continuum of Care Agencies

**2020 Polk County Continuum of Care Agencies (rev. 6/1/2022)**

**ACTS (Agency for Community Treatment Services)**
**Catholic Charities of Central Florida**
**Heart for Winter Haven**
**Heartland for Children**
**Lake Wales Care Center**
**Neighbor to Family**
**One More Child (Florida Baptist Children's Home)**
**Polk County Schools HEARTH Program**
**Salvation Army Lakeland**
**Salvation Army Winter Haven**
**Society of St. Vincent de Paul South Pinellas**
**Talbot House Ministries**
**Tri-County Human Services**
**Wilson House**
**Women and Youth (WAY) Center**
**Women's Resource Center**
**Youth and Family Alternatives (George Harris Youth Shelter)**