HOPE TOLSON CAMPUS CHECKLIST

REQUIRED FORMS-COLLECTION BEGINS ON APRIL 1, 2021

ALL RETURNING STUDENTS ARE REQUIRED TO SUBMIT:

- PROOF OF DC RESIDENCY
- Updated DC Health Certificate/DC Dental FORMS

ALL NEW STUDENTS ARE REQUIRED TO SUBMIT:

- COMPLETED ENROLLMENT APPLICATION
- FINAL REPORT CARD FROM PREVIOUS SCHOOL
- DC HEALTH CERTIFICATE FORM/IMMUNIZATION RECORDS
- DC DENTAL FORM
- PROOF OF DC RESIDENCY
- IEP (INDIVILUILIZED EDUCATION PLAN) OR 504 PLAN FROM PREVIOUS SCHOOL IF STUDENT RECEIVED SERVICES

MY SCHOOL DC
The Public School Lottery
MySchoolDC.org

SEAT ACCEPTANCE FORM
2021-22 School Year

Parents/Guardians: If you participated in the My School DC lottery, please complete this form to confirm your child accepts a seat in a My School DC school and submit it with other enrollment requirements to the school in person.

Student Information

You must fill out one form for each child you are enrolling that participated in the My School DC lottery.

First and Last Name:	**Date of Birth (MM/DD/YYYY):**
Current School (2020-21):	**Current Grade (2020-21):**
Enrolling School (2021-22):	**Enrolling Grade (2021-22):**

Records Release

Please read and sign the bottom of this form so that the enrolling school can request your child's records.

By signing this form, I authorize the enrolling school to request records from the current school for the student above. I also hereby authorize the enrolling school to request records from any other previous schools that the student above has attended. I understand that the enrolling school will not further transfer or communicate the records to any other party or agency without my express written consent except under authority of the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99).

Enrollment Confirmation

Please read and sign the bottom of this form to confirm your understanding of each statement and your child's enrollment for **2021-22**.

I understand that I cannot maintain enrollment at more than one school for **2021-22** and I am confirming my enrollment at the "Enrolling School" above.

I understand that once this form is submitted, I will give up my space at my current school for next school year (**2021-22**) and my current school will be notified that my space may be awarded to another family.

I understand that if I enroll as a result of receiving a waitlist offer from this school that I will be removed from the waitlists of all schools ranked below this school on my My School DC application.

Parent/Guardian Information

This should be the same person completing the form.

Signature: _____ **Print Name:** _____ **Date:** _____

FOR OFFICE USE ONLY **Application Tracking #:** _____

MY SCHOOL DC
The Public School Lottery
MySchoolDC.org

FORMULARIO DE ACEPTACIÓN DE CUPO
Para el año escolar 2021-22

Padre/madre/tutor: Si participó en la lotería de My School DC, complete este formulario para confirmar que su hijo(a) acepta el cupo en una escuela de My School DC y envíelo junto con otros requisitos de inscripción a la escuela en persona.

Información del estudiante

Debe completar un formulario por cada niño(a) que está inscribiendo que participó en la lotería de My School DC.

Nombre y apellido:	**Fecha de nacimiento (MM/DD/AAAA):**
Escuela actual (2020-21):	**Grado actual (2020-21):**
Escuela en la que se inscribe (2021-22):	**Grado en el que se inscribe (2021-22):**

Divulgación de los registros académicos

Lea y firme al pie de este formulario para que la escuela en la que se inscribe pueda solicitar los registros de su hijo(a).

Al firmar este formulario, autorizo a la escuela en la que se inscribe a solicitar los registros de la escuela actual para el estudiante mencionado anteriormente. Por la presente, también autorizo a la escuela en la que se inscribe a solicitar registros de cualquier otra escuela anterior a la que el estudiante haya asistido. Entiendo que la escuela en la que se inscribe no transferirá ni comunicará los registros a ninguna otra parte o agencia sin mi consentimiento expreso por escrito, excepto bajo la autoridad de la Ley de Privacidad y Derechos Educativos de la Familia (FERPA, por sus siglas en inglés) (20 U.S.C. § 1232g; 34 CFR Parte 99).

Confirmación de la inscripción

Lea y firme al pie de este formulario para confirmar que comprende cada declaración y la inscripción de su hijo(a) para 2021-22.

Entiendo que no puedo mantener la inscripción en más de una escuela para 2021-22 y estoy confirmando mi inscripción en la "Escuela de inscripción" mencionada más arriba.

Entiendo que una vez que se envíe este formulario, renunciaré a mi cupo en mi escuela actual para el próximo año escolar (2021-22) y se le notificará a mi escuela actual que mi cupo puede ser otorgado a otra familia.

Entiendo que, si me inscribo como resultado de recibir una oferta de la lista de espera de esta escuela, me retirarán de las listas de espera de todas las escuelas clasificadas por debajo de esta escuela en mi solicitud de My School DC.

Información del padre/madre/tutor:

Esta debe ser la misma persona que completa el formulario.

Firma: _____ **Nombre en letra de imprenta:** _____ **Fecha:** _____

FOR OFFICE USE ONLY **Application Tracking #:** _____

APPLICATION FOR ADMISSION/RE-ENROLLMENT
2021-2022 SCHOOL YEAR

****Please note the 2021-2022 Hope Tolson Campus age requirements.****
Pre-Kindergarten students must be 3 by September 31, 2021. Kindergarten students must be 5 September 31, 2021.

Please check if this is a: ☐ **New Student/Sibling of:** _____ ☐ **Returning Student**

Student Information

Last Name _____ First Name _____ Middle Initial _____ Birth

Date (mm/dd/yyyy) _____/_____/_____ Gender: ☐ Male ☐ Female Accepted grade in 2021-2022_____

School Last Attended / Head Start Programs_____

City/State _____ Ethnicity: _____ Race: _____

Primary Parent/Guardian Contact Information
(The address of the Primary Parent/Guardian will be the address used for the student's DC residency verification.)

1. Last Name _____ First Name _____

Relationship to Student _____

Street Address _____ Apt/Unit#_____

City_____ State _____ Zip Code_____ Ward_____

Home Phone: _____ Cell Phone: _____

Personal Email: _____

Employer: _____ Work Phone: _____

Secondary Parent/Guardian Contact Information (☐ Check this box if the home address is the same as Primary Parent/Guardian)

2. Last Name _____ First Name: _____

Relationship to Student: _____

***Street Address _____ Apt/Unit #_____

City_____ State_____ Zip Code_____

Home Phone: _____ Cell Phone: _____

Personal Email: _____

Employer: _____ Work Phone: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____

Address: _____ City/State: _____

Cell Number: _____ Work Number: _____ Home number: _____

Office Use Only:
Date received: ____/____/____ Time received: _____ Rec'd by: _____

How did you hear/learn about Hope Tolson Campus? (Please select AT LEAST one.)

☐ Referred by _____ Parent of _____
☐ Open House
☐ Mailings
☐ Internet
☐ MySchoolDC
☐ Other

Please read carefully. Sign and date at the bottom indicating that you agree to all terms and conditions.

To attend Hope Tolson Campus for free, I understand that I must complete and submit ALL required forms and Supporting documents listed below by the deadline. These materials will be collected after admission has been offered.

Required Forms - Collection will begin in April 1.

- Complete Registration Packet
- Student's Original Birth Certificate
- Immunization Records
- Imagine Hope Community Charter School Home Language Survey
- Copy of Individualized Education Plan (IEP)/504 plan (if applicable)
- Release of Student Records (withdrawal form from previous school)
- Copy of student records from prior school (report cards, test scores, etc.)
- Proof of DC Residency
- DC Child Physical & Oral Health Certificates (If child's visits are scheduled after 6/4, provide appointment cards)

I agree that all the answers given in this application, and any additional forms and supporting documents submitted in connection with this application are true, accurate and complete. I understand that falsification of residency in the District of Columbia will render my child ineligible to attend Hope Tolson Campus at no cost.

Parent/Guardian Signature _____ ***Date*** _____

Home Language Survey (HLS) Form

This form must be signed and dated by the Parent or Guardian. This form must be kept in the student's file.

School: _____ Student ID #: _____

Student's Last Name: _____ Student's First Name_____

English

1. Is a language other than English spoken in your home?
   ☐ No ☐ Yes _____ (specify language)
2. Does your child communicate in a language other than English?
   ☐ No ☐ Yes _____ (specify language)
3. What is your relationship to the child?
   ☐ Father ☐ Mother ☐ Guardian ☐ Other (specify)_____

If the answer to question 1 or 2 is "Yes", the law requires your child's English language proficiency to be assessed.

REGISTRAR PROCESS:

- If a parent/guardian does not speak English and your school does not have staff that speaks the parent/guardian's language, please use the Language Line for communication.
- If the HLS indicates a language other than English is spoken in the home, give the family the Referral Letter and refer the family to the Intake Center for assessment and orientation.

Español (Spanish)

1. ¿Se habla otro idioma que no sea el inglés en su casa?
   ☐ No ☐ Sí _____(idioma)
2. ¿Habla el estudiante un idioma que no sea el inglés?
   ☐ No ☐ Sí _____(idioma)
3. ¿Cuál es su relación con el estudiante?
   ☐ Padre ☐ Madre ☐ Guardián ☐ Otro (especifique)_____

Si la respuesta a la pregunta 1 ó 2 es " Sí ", la ley requiere que se evalúe la fluidez de su hijo/a en el idioma inglés.

Français (French)

1. Parlez-vous une langue autre que l'anglais à la maison ?
   ☐ Non ☐ Oui _____ (spécifiez la langue)
2. Votre enfant communique-t-il dans une langue autre que l'anglais ?
   ☐ Non ☐ Oui _____ (spécifiez la langue)
3. Quel est votre relation avec l'enfant ?
   ☐ Père ☐ Mère ☐ Tuteur ☐ Autre (spécifiez) _____

Si la réponse à la question 1 ou 2 est " Oui " , la loi exige que les compétences de votre enfant en anglais soit évaluées.

中文 (Chinese)

1. 您家庭中是否使用不是英语的另外一种语言?
   ☐ 否 ☐ 是 _____ (请指明语言)
2. 您的孩子会使用不是英语的另一种语言交流吗?
   ☐ 不会 ☐ 会 _____ (请指明语言)
3. 您和孩子的关系是什么?
   ☐ 父亲 ☐ 母亲 ☐ 监护人 ☐ 其它(请指明) _____

如果第一或第二项问题的答案为 "是" , 法律要求评估您孩子的英语熟练能力。

Tiếng Việt (Vietnamese)

1 Có ngôn ngữ nào khác ngoài tiếng Anh được nói ở nhà quý vị không?
☐ Không ☐ Có _____ (xin ghi rõ ngôn ngữ nào)

2 Con em quý vị có nói một ngôn ngữ nào khác ngoài tiếng Anh không?
☐ Không ☐ Có _____ (xin ghi rõ ngôn ngữ nào)

3. Xin cho biết liên hệ của quý vị với con em?
   ☐ Cha ☐ Mẹ ☐ Giám hộ ☐ Liên hệ khác (xin ghi rõ)

_____

Nếu trả lời của câu hỏi 1 hoặc 2 là " Có ", luật lệ đòi hỏi con em quý vị phải được thẩm định trình độ thông thạo Anh ngữ.

አማርኛ (Amharic)

1. በቤትዎ ውስጥ ከእንግሊዘኛ ሌላ የሚነገር ቋንቋ አለ ?
   ☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
2. ልጅዎ ከእንግሊዘኛ ሌላ የሚነጋገርብት ሌላ ቋንቋ አለ?
   ☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
3. ለልጁ ያለዎት ዝምድና ምንድን ነው?
   ☐ አባት ☐ እናት ☐ አሳዳጊ ☐ ሌላ_____ (ይግለጹ)

ለጥያቄ 1 ወይም 2 መልስዎ "አዎን" ከሆነ ፣ የልጅዎ የእንግሊዘኛ ቋንቋ ቅልጥፍና ችሎታው ደረጃ እንዲገመገም ህጉ ያዛል።

School Official's Comments:

School Official Signature Date

Parent/Guardian Signature Date

Hope Tolson Campus Media Release Form

I, _____ give permission for my
Parent/Guardian
Child, _____ to have their name and
Child's Name
Photograph appear in media available to the public (local newspapers, educational newsletters, websites pertaining to social studies, etc.)in recognition of their participation in any Hope Tolson Campus activities.

_____
Parent/Guardian Print Name

_____
Parent/Guardian Signature

_____
Date

PICK-UP AUTHORIZATION FORM

Child's Name: _____

Date of Birth: _____

Grade: _____

Mother's/Legal Guardian Name:
Father's/Legal Guardian Name:

Please list names and phone numbers of those authorized to pick up your child from school (other than parents/guardians above).

1. Name _____ Phone: _____
Relation to Child _____
2. Name _____ Phone: _____
Relation to Child
3. Name _____ Phone:
Relation to Child _____
4. Name _____ Phone: _____
Relation to Child _____

Please list names and phone numbers of those NEVER authorized to pick (OTHER than Parents/Guardians above).

1. Name _____
Relation to Child
2. Name _____
Relation to Child _____

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information

Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.*

Child's Last Name:	*Child's First & Middle Name:*	*Date of Birth:*	*Gender:* ☐M ☐F	*Race/Ethnicity:* ☐White Non-Hispanic ☐Black Non-Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_____
Parent or Guardian Name:	*Telephone:* ☐Home ☐Cell ☐Work.	*Home Address:*		*Ward:*
Emergency Contact Person:	*Emergency Number:* ☐Home ☐Cell ☐Work	*City/State (if other than D.C.)*		*Zip code:*
School or Child Care Facility:	☐Medicaid ☐Private Insurance ☐None Name/ID Number_____	*Primary Care Provider (PCP):*		

Part 2: Child's Health History, Examination & Recommendations

Health Practitioner: Form must be fully completed.

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3yrs) ☐ NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for children under age 6)*	Vision Screening Right 20/____ Left 20/____	☐ Glasses ☐ Referred ☐ Attempted	Hearing Screening Pass_____ Fail_____	☐ Device ☐ Referred ☐ Attempted

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizures	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred ☐ **Fluoride Varnish** Date:_____

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please provide details:

_____

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please provide details:

_____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements. ☐ NONE ☐ YES, please provide details. (For any medications or treatment required during school hours, a Licensed Health Practitioner's Medication Plan or Medication Authorization Order should be submitted with this form).

_____

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ **POSITIVE**	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Practitioner:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: **202-698-4040**
LEAD EXPOSURE RISKS	**LEAD TEST DATE:**		RESULT:	**Health Practitioner:** *ALL* lead levels must be reported to DC Childhood Lead and Healthy Housing Program: Fax: **202-535-2607**	

Part 4: Required Licensed Health Practitioner's Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed and recorded in accordance with the items specified on this form. At time of the exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

_____

Print Name	MD/APRN/NP Signature	Date
Address	Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information/civil liability waiver)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Section 1: Immunization: Please fill in or attach equivalent copy with Licensed Health Practitioner's signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Practitioner) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

Section 2: MEDICAL EXEMPTION. For Licensed Health Practitioner Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

Section 3: Alternative Proof of Immunity. To be completed by Licensed Health Practitioner or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____

Signature of Licensed Health Practitioner | Print Name or Stamp | Date

District of Columbia Oral Health (Dental Provider) Assessment Form

Parent/Guardian Instructions:
Part 1: Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address, list primary care provider, dental provider, and type of dental insurance. If the child has no dental provider and is uninsured, then please write "None" in each box.
Part 2: By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity representing this document. All information will be kept confidential. **This form will not be completed without parent/guardian signature. The parent/guardian must sign, print and date this part.**

Part 1: Child's Personal Information (to be completed by the parent/guardian)

Child's Last Name:	Child's First & Middle Name:	Date of Birth: MM/DD/YYYY	Gender: ❑ M ❑ F	School or Child Care facility: Grade:
Parent/Guardian Name 1:	Telephone 1: ❑ Home ❑ Cell ❑ Work	Home Address:		Ward:
Parent/Guardian Name 2:	Telephone 2: ❑ Home ❑ Cell ❑ Work	Emergency Contact:		Telephone:
Race Ethnicity: ❑ White Non-Hispanic ❑ Black Non-Hispanic ❑ Hispanic ❑ Asia or Pacific Islander ❑ Other				
Primary Care Provider (Medical):	Dentist/Dental Provider:	Type of Dental Insurance: ❑ Medicaid ❑ Private Insurance ❑ None ❑ Other		

Part 2: Required Parent/Guardian Signatures

Parent/Guardian Release of Health Information.
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health.

PRINT NAME of parent/guardian: SIGNATURE of parent/guardian: Date:

Dental Provider Instructions:
Part 3: Circle Yes or No in findings column. For Yes, please explain in Comments Section.
Part 4 Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete, refer patient for follow up care. Dentist must sign, date, and provide required information.

Part 3: Child's Findings and Parent Recommendations (please indicate in findings column)

CONFIDENTIAL FORM

	Findings	Comments
Gingival inflammation	Y N	
Plaque and/or calculus	Y N	
Abnormal gingival attachments	Y N	
Malocclusion	Y N	
Treated Dental Caries	Y N	
Untreated dental caries	Y N	❑ Check box if Urgent
Sealants on permanent molars	Y N	
Cleft lip and palate	Y N	
Preventative services completed	Y N	What kinds of preventative services were completed? ❑ Prophy ❑ Fluoride ❑ Oral Hygiene

Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ❑ is completed ❑ is not completed ❑ under treatment ❑ refused treatment ❑ not necessary.
The child has ongoing ❑ urgent ❑ non-urgent treatment needs and is under treatment ❑ by me or ❑ has been referred to:

DDS/DMD Signature: Print Name:

Address: Fax: Phone: Date:

District of Columbia Health Certificate:
This Form replaces the previous version of the District of Columbia Oral Health (Dental Provider) Assessment Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, all school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examination. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that children 3 years of age and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment Form completed. This form is a confidential document Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC Schools and other providers

Acceptable Supporting Documentation Checklist

1. (One item is needed from this list to verify residency. The address and name on each of the items must be the same.)

- ○ **Pay stub:** A valid paystub issued within forty-five (45) days of providing proof of residency. Must contain the name of person enrolling the student or the name of the adult student showing his/her current DC home address, and withholding of only DC personal income tax for the current tax year.
- ○ **Unexpired official documentation of financial assistance from the Government of the District of Columbia:** Issued to the person enrolling the student or the adult student and current at the time presented to the school, including, but not limited to, Temporary Assistance for Needy Families (TANF), Medicaid, the State Child Health Insurance Program (SCHIP), Supplemental Security Income, housing assistance or other programs.
- ○ **Certified copy of Form D40:** Certified by the DC Office of Tax and Revenue, with the name of person enrolling the student or the name of the adult student as evidence of payment of DC taxes for the current or most recent tax year.
- ○ **Current Military housing orders:** Showing the name of the person enrolling the student or the name of the adult student, and the residening District address, including but not limited to a DEERS statement or other official communication on military letterhead.
- ○ **Embassy letter:** Issued within the past twelve (12) months showing the name of the person enrolling the student or the name of the adult student, indicating that the caregiver and the dependent student or the adult student currently live on embassy property in the District of Columbia or will reside on DC property confirmed by the embassy during the relevant school year, and an official embassy seal.

2. (Two items are needed from this list to verify residency. The address and name on each of the items must be the same.)

- ○ Valid and unexpired **DC motor vehicle registration** showing the name of the person enrolling the student or the name of the adult student and his/her current District home address.
- ○ Valid and unexpired **lease or rental agreement with a separate proof of payment of rent**, in the name of the person enrolling the student or the name of the adult student, for a period within two (2) months immediately preceding the school's review of residency documentation, for the current DC address at which the student actually resides.
- ○ Valid and unexpired **DC motor vehicle operator's permit** or official government issued non-driver identification in the name of the person enrolling the student or the name of the adult student showing his/her current DC home address.
- ○ **Utility bill** (***only gas, electric, and water bills are acceptable***) with a separate **paid receipt** showing **payment of the bill**, from a period within the two (2) months immediately preceding the school's review of residency documentation, listing the name of the person enrolling the student or the name of the adult student and his/her current DC home address.

3. (No supporting documentation required. A signature is required by enrolling person in Part C.)

- ○ **Homeless:** There is evidence that the student is homeless and the school's homeless liaison has provided the appropriate homeless information.
- ○ **Ward of the District of Columbia:** Proof that child is a ward of the District of Columbia, in the form of a court order or official documentation from DC Child and Family Services Agency.

4. (enrolling families/students consent to electronic verification of residency.)

- ○ **Office of Tax and Revenue:** Re-enrolling families/students agree to verify residency using OTR residency verification process. Enrolling person must login to a separate residency validation system. Guidance documentation provided by the enrolling school.
- ○ **DC Financial Assistance:** Participation in the identified District financial assistance or public benefits progam in which information is fed directly to OSSE through an intra-agency data sharing agreement. These programs include Medicaid, Supplementation Nutrition Assistance Program (SNAP), or Temporary Assistance for Needy Families (TANF).

Penalty for False Information:

Any person, including any District of Columbia public school or public charter school official, who knowingly supplies false information to a public official in connection with student residency verification shall be subject to charges of tuition retroactively, and payment of a fine of not more than $2,000 or imprisonment for not more than 90 days, but not both fine and imprisonment, pursuant to the District of Columbia Nonresident Tuition Act, approved September 8, 1960 and amended by the District of Columbia Public Schools and Public Charter School Student Residency Fraud Prevention Amendment Act of 2012 (D.C. Code §38-312). The case of any such person may be referred by the Office of the State Superintendent of Education to the Office of the Attorney General