



APPLICATION FOR STATE ELIGIBLE FREE PREKINDERGARTEN 2026 - 2027

Child's Name: _____ Date: _____

Parent/Guardian Name(s): _____

Home Address: _____

Phone Number: _____ Email Address: _____

The child's name written above is applying to be considered, based on criteria shown below, for entry into the free Cleburne ISD prekindergarten program. Prekindergarten campus assignments are subject to space available.

Criteria for admittance to the free Cleburne ISD prekindergarten program:

- Child will be 4 years old on or before September 1, 2026
- Child is a resident of Cleburne ISD
- At least one of the following conditions must also be met:

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ONLY**

Emergent Bilingual (EB)

- Child is unable to speak and comprehend the English language.
- Child will be tested with an oral English assessment.

Homeless

- Child resides in a temporary housing situation due to economic hardship.
- Complete a Student Residency Questionnaire.

Foster Care Eligibility

- Copy of DFPS or Child Protective Services verification letter is required. To request letter, email Prekverificationltrs@dfps.texas.gov

Star of Texas Award Recipient

- Parent or Guardian of the child is a person eligible for the Star of Texas Award as a peace officer, firefighter, or emergency medical first responder. **Appropriate documents must be attached.**

Military Eligibility

- Parent or guardian of the child is an active-duty member of the armed forces of the United States, including state military forces or a reserve component of the armed forces, who is ordered to active duty by proper authority. **Military ID (DoD) must be shown, DO NOT COPY.**

OR

Parent or guardian of the child is a member of the armed forces of the United States, including state military forces or a reserve component of the armed forces, who was injured or killed while serving on active duty. **Appropriate documents must be attached.**

Child of Person Employed as a Classroom teacher

- Parent or guardian of the child must be employed as a classroom teacher at a public primary or secondary school in the school district that offers a pre-k class. **Letter from HR confirming teacher status.**

Staff member must
initial next to verified

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Income Eligibility

- Information must be completed in the section below:

STEP 1 ASSISTANCE

Do any household members currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR? If **NO** go to STEP 2. If **YES**, write the EDG number here: _____ then go to STEP 3. Be prepared to provide SNAP or TANF notice of benefits letter.

STEP 2 HOUSEHOLD INCOME

A household member is defined as "anyone who is living with you and shares income and expenses, even if not related."

List all household members even if they do not receive income. For each member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. Report how often by income type: W=Weekly, E=Every 2 Weeks, T=Twice per Month, M=Monthly, A=Annually. If they do not receive income from any source, write '0'. If you enter '0' or leave any field blank, you are certifying that there is no income to report. You may attach an additional sheet if more space is needed.

Names of ALL household members	Work Earnings	How Often? (circle one)	Public Assistance / Child Support/ Alimony	How Often? (circle one)	Pensions/ Retirement/ Social Security/ SSI/VA Benefits/ All Other	How Often? (circle one)
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A
	\$	W E T M A	\$	W E T M A	\$	W E T M A

STEP 3 SIGNATURE

I understand that school district officials may verify the information on the application. If investigation indicates false information has been provided and the child was not eligible to participate in the program at the time of the application, the child may be withdrawn from the program to make room for a child who is eligible. I certify that all the above information is true and correct, and ALL household members and income are reported. I understand that this information is being given for the receipt of funds, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state laws.

Parent/Guardian Signature

Date

INCOME ELIGIBILITY GUIDELINES											
Effective from July 1, 2025 to June 30, 2027											
HOUSEHOLD SIZE	FEDERAL POVERTY GUIDELINES	REDUCED PRICE MEALS = 185%					FREE MEALS = 130%				
		ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
48 CONTIGUOUS STATES, DISTRICT OF COLUMBIA, GUAM, AND TERRITORIES											
1	15,980	29,526	2,461	1,231	1,136	568	20,748	1,729	865	798	399
2	21,640	40,034	3,337	1,669	1,540	770	28,132	2,345	1,173	1,082	541
3	27,320	50,542	4,212	2,106	1,944	972	35,516	2,960	1,480	1,366	683
4	33,000	61,050	5,088	2,544	2,349	1,175	42,900	3,575	1,788	1,650	825
5	38,680	71,558	5,964	2,982	2,753	1,377	50,284	4,191	2,096	1,934	967
6	44,360	82,066	6,839	3,420	3,157	1,579	57,668	4,806	2,403	2,218	1,109
7	50,040	92,574	7,715	3,858	3,561	1,781	65,052	5,421	2,711	2,502	1,251
8	55,720	103,082	8,591	4,296	3,965	1,983	72,438	6,037	3,019	2,786	1,393
For each additional family member, add	5,680	10,508	876	438	405	203	7,384	616	308	284	142

____ APPROVED ____ REJECTED

Signature of Campus Principal or Designee

Date