GSRP PreK Application

2026-2027

Qualifications for GSRP:

- Your child must be 4-years-old (but not yet 5-years-old) by September 1, 2026
  We can accept children who turn 4 between September 2 and December 1, but they can only be enrolled after September 1, if there is space available
- You must live in Berrien County
  Families from neighboring counties may apply, but must complete a Cross County Prior Approval form

Prioritization Factors:

- Income
- Homelessness*
- Foster Care Placement*
- Individualized Education Program (IEP)

Each applicant will be ranked by the family's federal poverty level (FPL), and programs will enroll children in the lowest FPL brackets first. Children who are experiencing homelessness, are in foster care, have an IEP, or were previously enrolled in Strong Beginnings are prioritized regardless of income.

**Children whose household income is at or below 100% FPL, who are experiencing homelessness, or who are in foster care qualify to be served by Head Start, and must apply there first. Please contact Flowers Early Learning at flowersearlylearning.org or 1-800-792-0366. If a family qualifies for Head Start but wishes to be served by GSRP, the GSRP site must first seek approval from Head Start.*

Required Documentation:

- ☐ **Proof of Age** - Such as a birth certificate, passport, immigration record, or baptismal certificate
- ☐ **Proof of Residency** - Such as a driver's license, rent receipt, utility bill, or letter from shelter or host (if between homes)
- ☐ **Child Information Record**
- ☐ IEP, if applicable
- ☐ Health Appraisal Form - *Completed by a medical provider, must be submitted within 30 days after the child's start date*

These materials were developed under a grant awarded by MiLEAP

GSRP Preschool Locations in Berrien County

Please note - acceptance into a GSRP classroom does not guarantee that you will be accepted into that school's Kindergarten or Young 5's program, you will have to follow the process or school of choice process per school.

School Districts

Benton Harbor Area Schools
Discovery Enrichment Center
465 S. McCord Street - Benton Harbor
Phone - (269) 605-1601
Email - Sandra.tyler@bhas.org
Website - dec.bhas.org/o/dec
Full Day Program, Monday-Thursday
Transportation provided within District

Benton Harbor Charter School Academy
455 Riverview Drive, Suite 1 - Benton Harbor
Phone - (269) 925-3807 ext. 164
Email - nicoledale@choiceschools.com
Website - www.bentonharborcharter.com
Full Day Program, Monday-Thursday
Transportation provided within District

Berrien Springs Public Schools
430 W. Mars Street. - Berrien Springs
Phone - (269) 473-0703
Email - jwallace@homeoftheshamrocks.org
or csherman@homeoftheshamrocks.org
Half Day Program, Monday-Thursday
Full Day Program, Monday-Thursday
Transportation provided within District

Brandywine Community Schools
1620 LaSalle Ave. - Niles
Phone - (269) 684-6511
Email - mhigh@brandywinebobcats.org
Website - www.brandywinebobcats.org
Full Day Program, Monday-Thursday

Buchanan Community Schools
109 Ottawa St. - Buchanan
Phone - (269) 695-8409
Email - ejohnson@buchananschools.com
Website - www.buchananschools.com
Full Day Program, Monday-Thursday
Transportation provided within District

Coloma Community Schools
262 S. West Street - Coloma
Phone - (269) 468-2424
Email - rpounders@ccs.coloma.org
Website - ces.coloma.org
Extended Week Program, Monday-Friday
Transportation provided within District

Countryside Academy
4722 Meadowbrook Road - Benton Harbor
Phone - (269) 944-3319 ext. 219
Email - mbeckmann@countrysideacademy.org
Website - www.countrysideacademy.org
Full Day Program, Monday-Thursday
Transportation provided within District

Eau Claire Public Schools
6238 West Main Street - Eau Claire
Phone - (269) 461-6191
Email - jrumsey@eauclaireps.com
Website - eauclaireps.com
Full Day Program, Monday-Thursday
Transportation provided within District

Watervliet Public Schools
287 Baldwin Ave. - Watervliet
Phone - (269) 463-0820
Email - twilliams@watervlietps.org
Website - www.watervlietps.org
Full Day Program, Monday-Thursday

Community Based Organizations

The Blessed Noah's Ark Day Care
1844 Colfax Ave. - Benton Harbor
Phone - (269) 252-5112
Email - tynishamurphy22@gmail.com
Full Day Program, Monday-Thursday
Transportation provided

The Children's Center - Niles
210 Main Street - Niles
Phone - (269) 683-0405
Email - kelsey@weloveourfamilies.com
Website - www.thechildrenscenterinc.com/preschool2.html
Full Day Program, Monday-Thursday

The Children's Center - Peace Boulevard
219 Peace Blvd - St. Joseph
Phone - (269) 683-0405
Email - Kelsey@weloveourfamilies.com
Website - www.thechildrenscenterinc.com/preschool2.html
Full Day Program, Monday-Thursday

Immanuel EC Development Center
9650 Church Street - Bridgman
Phone - (269) 465-6031 ext. 114
Email - barba@immanuelbridgman.org
Full Day Program, Monday-Thursday

Montessori Children's Center
1000 Miners Road - St. Joseph
Phone - (269) 256-4456
Email - Kelsey@weloveourfamilies.com
Website - montessorichildrenscenter.com/
Extended Week Program, Monday-Friday

Stevensville United Methodist Children's Center
5506 Ridge Road - Stevensville
Phone - (269) 429-1069
Email - director2.sumcc@gmail.com
Full Day Program, Monday-Thursday

Trinity Lutheran - Berrien Springs
9123 George Avenue - Berrien Springs
Phone - (269) 473-1811
Email - school@trinityberrien.org
Website - www.trinityberrien.org/daycare
Full Day Program, Monday-Thursday

Trinity Lutheran Early Childhood Center
613 Court Street - St. Joseph
Phone - (269) 983-0040
Email - jennifer.reynnells@discovertrinity.org
Website - www.trinitystjoe.org
Full Day Program, Monday-Thursday

YMCA of Greater Michiana - BH/SJ YMCA
3655 Hollywood Rd - St. Joseph
Phone - (269) 428-9622
Email - mmaier@ymcagm.org
Website - www.ymcagm.org/GSRP
Half or Full Day, Monday-Thursday
Extended Week Program, Monday-Friday

YMCA of Greater Michiana - Northside Child Development Center
2020 N. Fifth Street - Niles
Phone - (269) 683-1982
Email - mskalla@ymcagm.org
Website - www.ymcagm.org/GSRP
Half or Full Day, Monday-Thursday
Extended Week Program, Monday-Friday
Transportation provided

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BERRIEN RESA · PreK for ALL · Great Start Readiness Program Michigan's Nationally Recognized Pre-K Program · STRONG Beginnings PRESCHOOL FOR 3 YEAR OLD CHILDREN

BERRIEN COUNTY GSRP APPLICATION 2026-2027

Completing an application doesn't automatically enroll you into GRSP. All applications/enrollments are pending per review of qualifications and the state GSRP budget. All final notifications will come from teachers/sites prior to the fall start.

PROGRAM PREFERENCE

- ☐Benton Harbor Area Schools
- ☐Benton Harbor Charter School
- ☐Berrien Springs Public Schools
- ☐The Blessed Noah's Ark
- ☐Brandywine Community Schools
- ☐Buchanan Community Schools
- ☐The Children's Center - Niles
- ☐The Children's Center - Peace
- ☐Coloma Community Schools
- ☐Countryside Academy
- ☐Eau Claire Public Schools
- ☐Immanuel EC Development Center
- ☐Montessori Children's Center
- ☐Stevensville United Methodist
- ☐Trinity Lutheran - Berrien Springs
- ☐Trinity Lutheran - St. Joseph
- ☐Watervliet Public Schools
- ☐YMCA - Northside
- ☐YMCA - BH/SJ YMCA

CHILD INFORMATION

Child's Legal Name: _____ _____ _____ Date of Birth: ___/___/_____
First Name Middle Name Last Name mm dd yyyy

Gender: ☐ Male ☐ Female

Ethnicity: Hispanic or Latino ☐Yes ☐No

Race: American ☐ African American or Black ☐ Indian or Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian or Pacific Islander ☐ Caucasian or White ☐ Two or more races

Address_____ City _____ Zip_____ County_____

Phone Number: _____ School District of Residence:_____

Did the child participate in Strong Beginnings in the 2025/2026 school year? ☐Yes ☐No

FAMILY INFORMATION

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Joint Custody (If joint, Physical or Legal, Explain) _____
☐ Legal Guardian ☐ Grandparents ☐ Foster Care ☐ Other: Explain _____

Parent/guardian Name 1:_____
Parent/guardian date of birth:_____
Address: (if different from above):_____
Current Employer:_____
Employers Address:_____
Primary Phone#:_____
Alternative Phone#:_____
Email: _____

Parent/guardian Name 2:_____
Parent/guardian date of birth:_____
Address: (if different from above):_____
Current Employer:_____
Employers Address:_____
Primary Phone#:_____
Alternative Phone#:_____
Email: _____

EMERGENCY CONTACTS other than parent/guardian

1. _____ _____ _____ ____ _____ _____
   Name Street Address City State Phone Number Relationship to child
2. _____ _____ _____ ____ _____ _____
   Name Street Address City State Phone Number Relationship to child

INCOME & PROGRAM ELIGIBILITY FACTORS

Total household income: $_____ Number in Household: _____
If you do not provide this information, your child cannot be enrolled until after August 1.

Is the child experiencing homelessness? ☐Yes ☐No

Is the child in foster care? ☐Yes ☐No

Does the child have an Individualized Education Program (IEP)? ☐Yes ☐No
If yes, a copy must be provided.

Parent/Guardian Signature_____ **Date**_____

FOR OFFICE USE ONLY - ***For enrollment prioritization and PowerSchool documentation***

% FPL Bracket:
- ☐ 01: 0-50%
  - ☐ Approved for GSRP by HS
- ☐ 02: 51-100%
  - ☐ Approved for GSRP by HS
- ☐ 03: 101-150%
- ☐ 04: 151-200%
- ☐ 05: 201-250%
- ☐ 06: 251-300%
- ☐ 08: 301-350%
- ☐ 09: 351-400%
- ☐ 10: 401-450%
- ☐ 11: 451% and above

Eligibility Factors:
- ☐ A: Homelessness (placed in FPL Bracket 01)
- ☐ B: Foster Care (placed in FPL Bracket 01)
- ☐ C: IEP (placed in FPL Bracket 01, for GSRP prioritization purposes)

Automatic Enrollment:
- ☐ Strong Beginnings Participant

Date Application was Received: _____

Order in Which Application was Received: _____

Application Prioritization Rank #:_____

I verify that I have reviewed the following documentation with the family:
- ☐ **Proof of Age** - Such as a birth certificate, passport, immigration record, or baptismal certificate
- ☐ **Proof of Residency** - Such as a driver's license, rent receipt, utility bill, or letter from shelter or host (if between homes)
- ☐ IEP - If applicable

_____ _____
GSRP Staff Signature Date of Verification

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Berrien RESA Photo Release Form for GSRP Students

☐ I **give permission** for my son/daughter photo/image to be used. Please complete the form below

☐ I **do not give permission** for my son/ daughter photo/image to be used. However, please complete the Guardian's name and Minor's name sections as well as sign and date the form.

I, _____, give the GSRP school/site, Berrien RESA and its affiliated programs permission to use the photo/image/video of the minor named below and grant the GSRP school/site and Berrien RESA all rights to use these photo/image/video in any medium for educational, promotional, advertising or other purposes that support the mission of the District. I agree that all rights to the photo/image/video belong to GSRP/Berrien RESA.

Guardian's Name:_____

Minor's Name:_____

Parent/Guardian's Signature:_____

Date:_____

Address:_____

Phone:_____

Email:_____

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GSRP Underage Consideration

****Only complete if your child will turn 4 after September 1 - December 1****

GSRP Underage Eligibility Consideration-Special Circumstances for Children turning 4 **after** September 1st - December 1st.

I understand that a child who turns 4 years old **after** September 1st - December 1st can be considered for enrollment in the Free Preschool in Berrien County by requesting this Special Consideration.

I also understand that the intention of the Great Start Readiness Preschool program is to be provided the year before a child enters kindergarten, therefore I am requesting that eligibility for enrollment into a Great Start Readiness Preschool program be considered for my child because I plan to request early entry into kindergarten the following year.

_____ and _____.
Child's full name Date of Birth

I understand that this does not guarantee my child a classroom placement in GSRP for the school year and that I will be notified of the enrollment status after **September 1.**

_____ _____
Parent Signature Date

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CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Learning, and Potential - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)					Child's Date of Birth
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)		2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd Phone (if applicable) ( )
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address (optional)		
Employer Name		Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)					
Allergies, Special Needs and/or Special Instructions? No ☐ Yes ☐ If yes, explain: (Attach additional sheets, if necessary.)					

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See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	**2.**	( )
3.	( )	**4.**	( )
5.	( )	**6.**	( )

Parent/Legal Guardian Initials:

_____I give permission to _____, licensed by the Department of Lifelong Education, Advancement, and Potential, to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

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MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual, and emotional needs of the child. Fill out the information requested in Section 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).

SECTION 1 – PERSONAL

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1. Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2. Anaphylaxis	
☐	☐	☐	3. Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	4. Hay Fever, Asthma, or Wheezing	
☐	☐	☐	5. Eczema or Frequent Skin Rashes	
☐	☐	☐	6. Convulsions/Seizures	
☐	☐	☐	7. Heart Trouble	
☐	☐	☐	8. Diabetes	
☐	☐	☐	9. Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10. Trouble with Passing Urine or Bowel Movements	If yes, describe

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☐	☐	☐	11. Shortness of Breath	
☐	☐	☐	12. Speech Problems	
☐	☐	☐	13. Menstrual Problems	
☐	☐	☐	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
☐	☐	☐	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Examiner's Initials

☐ Yes ☐ No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
☐	☐	Vision	Visual Acuity	☐	☐	☐
		Date	Muscle Imbalance	☐	☐	☐
			Other	☐	☐	☐
☐	☐	Hearing	☐ Audiometer (R= Right, L=Left)			
		Date	☐ OAE (R= Right, L=Left)			
			☐ Other (R= Right, L=Left)			
☐	☐	Urinalysis	Sugar	☐	☐	☐
			Albumin	☐	☐	☐
			Microscopic	☐	☐	☐
☐	☐	Blood Lead Level	Level ug/dl	☐	☐	☐
		Date				

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Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight	Height	☐	☐	☐
			Weight	☐	☐	☐
☐	☐	Other	Other	☐	☐	☐
☐	☐	Hemoglobin/Hematocrit	⇨	☐	☐	☐
☐	☐	Blood Pressure	Reading	☐	☐	☐

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

Examinations and/or Inspections

Essential Findings Deviating from Normal — Exam Date

SECTION 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
Haemophilus Influenzae type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

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Influenza (IIV/LAIV)	1.	2.	3.
	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

Additional Vaccines Specify Date & Type

Type of Vaccine(s)	Date of Vaccine(s)
1.	
2.	
3.	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.

***Note:** According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious, and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

History of Chickenpox Disease? If yes, date

☐ Yes ☐ No

☐ Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature Title Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

☐ Yes ☐ No

Check all that apply

☐ Classroom ☐ Playground ☐ Gymnasium

☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

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SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service
☐ Dental Exam ☐ Dental Assessment

Findings (Check all that apply)
☐ No findings ☐ Treated Decay ☐ Untreated Decay

Recommendations (Check one)
☐ Routine Care
☐ Referral for dental treatment
☐ Referral for urgent dental care

Provider Signature | Date

Check one
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print) | Degree or License | Telephone Number

Examiner's Signature | Date

Address | City | State MI | Zip Code

Information required for:
Early On – Hearing and Vision Status; Diagnosis; Health status
Child Care Licensing – Physical Exam, Restrictions, Immunizations
Head Start/Early Head Start – Determination that child is up-to-date on a schedule of age-appropriate preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.
Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

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