OFFICIAL CERTIFICATION LETTER FOR CANCELLATION BENEFITS

NOTE TO BORROWER: Fill out PART A and sign to request a deferment/cancellation of payments for the reason indicated by your employer in Part B, C, D, E, F, G, H, I, or J (whichever applies)

PART A

EMPLOYEE NAME: _____ SSN: _____
Last First MI

LEGAL NAME OF AGENCY: _____

AGENCY ADDRESS: _____ AGENCY PHONE NO: (_____) _____
Street

_____
City State Zip

_____
Signature

NOTE TO EMPLOYER: Please complete, answer all questions, sign, include your title and date PARTS B, C, D, E, F, G, H, I, or J as applicable. This form may not be certified more than 30 days before the date of employment.

PART B: NURSE OR MEDICAL TECHNICIAN (*Code of Federal Regulations*, Sections 674.51 & 674.56)

I certify that the above employee is or is expected to be a full-time employee of this institution or facility for twelve consecutive months beginning _____ and ending _____.

In what job capacity? _____ **(Attach job description)**

☐ Medical Technician: An allied health professional (working in fields such as therapy, dental hygiene, medical technology, or nutrition) who is certified, registered, or licensed by the appropriate state agency in the state in which he or she provides health care services and assists, facilitates, or complements the work of physicians and other specialists in the health care system.

☐ Nurse: A licensed practical nurse, a registered nurse, or other individual who is licensed by the appropriate state agency to provide nursing services.

Original Date Received
Med Tech/RN License: _____ **OR** **Original** Date Passed
State Board: _____

_____ /
SIGNATURE OF CERTIFYING OFFICIAL DATE

(SEAL)

_____
TITLE

PART C: EARLY INTERVENTION SERVICES (*Code of Federal Regulations,* Section 674.51 & 674.56)

YES **NO**
☐ ☐ 1. Is this program a public or other non-profit program under public supervision by the lead agency as authorized in section 632(4) of the Individuals with Disabilities Education Act?

YES **NO**
☐ ☐ 2. Is your employee (or is your employee expected to be) a full-time employee of this agency for 12 consecutive months?
If yes, indicate beginning _____ and ending _____ dates.
In what job capacity?_____ (**Attach job description**)

YES **NO**
☐ ☐ 3. Is your employee a qualified professional provider of early intervention services designed to meet developmental needs of an infant or toddler with a disability in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development.

YES **NO** 4. Does your employee provide services to infants and toddlers with disabilities from birth to 2 years old, **inclusive**?
☐ ☐

_____ /
SIGNATURE OF CERTIFYING OFFICIAL DATE

(SEAL)

_____
TITLE

Please see other side

PART D: PUBLIC/PRIVATE NON-PROFIT CHILD OR FAMILY SERVICE AGENCY (*Code of Federal Regulations,* Section 674.56(b))

YES NO

☐ ☐ 1. Is this organization a public or private non-profit child or family service agency? Indicate which _____.

YES NO

☐ ☐ 2. Is your employee (or is your employee expected to be) a full-time employee of this agency for 12 consecutive months? If yes, indicate beginning _____ and ending _____ dates.

In what job capacity? _____ (**Attach job description**)

YES NO

☐ ☐ 3. Is your employee providing, or supervising the provision of, services to high-risk children and their families who are from low-income communities? (Low income communities are those in which there is a high concentration of children eligible to be counted under Title I of the Elementary and Secondary Education Act of 1965, as amended.)

YES NO

☐ ☐ 4. Are the high-risk children served individuals under the age of 21, who are low-income **OR** at risk of abuse **OR** neglect, have been abused **OR** neglected, have serious emotional, mental, **OR** behavioral disturbances, reside in placements outside their homes, **OR** are involved in the juvenile justice system?

_____ /_____

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(SEAL)

_____

TITLE

PART E: HEAD START (*Code of Federal Regulations,* Section 674.58) Head Start is a preschool program carried out under the Head Start Act (Subchapter B, Chapter 8 of Title VI of Pub.L. 97-35, the Budget Reconciliation Act of 1981, as amended; formerly authorized under Section 222(a) (1) of the Economic Opportunity Act of 1964). (42 U.S.C. 2809(a)(1)).

YES NO

☐ ☐ 1. Is your employee (or is your employee expected to be) a full-time staff member of this agency? If yes, indicate beginning _____ and ending _____ dates.

In what job capacity? _____ (**Attach job description**)

YES NO

☐ ☐ 2. Does the program operate for a complete academic year or its equivalent?

YES NO

☐ ☐ 3. Does your employee's salary exceed the salary of a comparable employee working in the local educational agency of the area served by the local Head Start Program?

YES NO

☐ ☐ 4. Is your employee or will your employee be considered a full-time staff member regularly employed in a full-time professional capacity to carry out the educational part of a Head Start Program?

_____ /_____

SIGNATURE OF CERTIFYING OFFICIAL DATE

(SEAL)

_____

TITLE

Continued on next page

PART F: LAW ENFORCEMENT (*Code of Federal Regulations,* Section 674.57)

YES **NO**

☐ ☐ 1. Is this a local, state or Federal law enforcement or corrections agency that is publicly funded, and do its principal activities pertain to crime prevention, control, or reduction or the enforcement of the criminal law?

YES **NO**

☐ ☐ 2. Is this agency primarily responsible for the enforcement of criminal law?

YES **NO**

☐ ☐ 3. Is your employee (or is your employee expected to be) a full-time employee of this agency for 12 consecutive months beginning _____ and ending _____ dates and, during that time, has your employee been (or will your employee be) a sworn law enforcement or corrections officer (effective date _____) **OR** person whose principal responsibilities are **unique** to the criminal justice system, **and** are these responsibilities essential in the performance of the agency's **primary** mission?

In what job capacity? _____ (**Attach job description**)

YES **NO**

☐ ☐ 4. Are your employee's official **primary** responsibilities administrative or supportive, such as those that involve typing, filing, accounting, office procedures, purchasing, stock control, food service, or building, equipment or grounds maintenance?

_____ / _____

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(SEAL)

_____

TITLE

PART G: LIBRARIAN (*Code of Federal Regulations,* Section 674.56(f))

YES **NO**

☐ ☐ 1. Does this employee work in an elementary or secondary school that qualifies for Title I funding?

YES **NO**

☐ ☐ 2. Does this employee work in a public library that serves a geographic area that includes one or more Title I schools?

YES **NO**

☐ ☐ 3. Is your employee (or is your employee expected to be) a full-time employee of this agency for 12 consecutive months? If yes, indicate beginning _____ and ending _____ dates. (**Attach job description**)

YES **NO**

☐ ☐ 4. Does this employee have a master's degree in library science? If yes, **attach a copy**.

_____ / _____

SIGNATURE OF CERTIFYING OFFICIAL DATE

(SEAL)

_____

TITLE

Please see other side

PART H: SPEECH-LANGUAGE PATHOLOGIST (*Code of Federal Regulations,* Section 674.56(g))

YES **NO**

☐ ☐ 1. Does this employee work **exclusively** with Title I eligible schools?

YES **NO**

☐ ☐ 2. Does this employee have a master's degree? If yes, **please attach a copy**.

YES **NO**

☐ ☐ 3. Is your employee (or is your employee expected to be) a full-time employee of this agency for 12 consecutive months? If yes, indicate beginning _____ and ending _____ dates. (**Attach job description**)

_____ /_____

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(SEAL)

_____

TITLE

PART I: PRE-KINDERGARTEN PROGRAM (*Code of Federal Regulations,* Section 674.58)

YES **NO**

☐ ☐ 1. Is your employee (or is your employee expected to be) a full-time employee of this agency? If yes, indicate beginning _____ and ending _____ dates.

In what job capacity? _____ (**Attach job description**)

YES **NO**

☐ ☐ 2. Does the program operate for a complete academic year or its equivalent?

YES **NO**

☐ ☐ 3. Does your employee's salary exceed the salary of a comparable employee working in the local educational agency of the area served by the local pre-kindergarten program?

YES **NO**

☐ ☐ 4. Is this pre-kindergarten program state funded and addresses the children's cognitive, social, emotional, and physical development?

5. Please provide the age group that you serve, **inclusive**._____

_____ /_____

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(SEAL)

_____

TITLE

PART J: CHILD CARE PROGRAM (*Code of Federal Regulations,* Section 674.58)

YES **NO**

☐ ☐ 1. Is your employee (or is your employee expected to be) a full-time employee of this agency? If yes, indicate beginning _____ and ending _____ dates.

In what job capacity? _____ (**Attach job description**)

YES **NO**

☐ ☐ 2. Does the program operate for a complete academic year or its equivalent?

YES **NO**

☐ ☐ 3. Does your employee's salary exceed the salary of a comparable employee working in the local educational agency of the area served by the local child care program?

YES **NO**

☐ ☐ 4. Is this child care program licensed or regulated by the state? If yes, **provide a copy of the appropriate document**.

5. Please indicate the number of children served in this child care program **and** the number of hours per day that it operates.

_____

_____ /_____

SIGNATURE OF CERTIFYING OFFICIAL DATE

(SEAL)

_____

TITLE