

# 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 \_\_\_\_\_ or Original Date Passed \_\_\_\_\_  
Med Tech/RN License: \_\_\_\_\_ 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 a handicapped infant's or toddler's developmental need in any one or more of the following areas: physical development, cognitive development, language and speech development, psycho-social development, or self-help skills (as defined in section 632(4) of the Individual's with Disabilities Education Act)?

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

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\_\_\_\_\_  
TITLE

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**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**

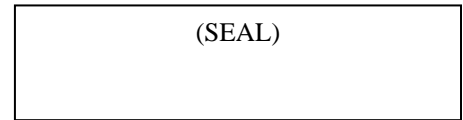
3. Is your employee providing, or supervising the provision of, services to high-risk children and their families who are from low-income communities? (Low income communities are those in which there is a high concentration of children eligible to be counted under Title I of the Elementary and Secondary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

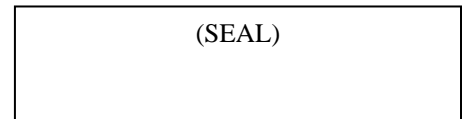
3. Does your employee's salary exceed the salary of a comparable employee working in the local educational agency of the area served by the local Head Start Program?

**YES NO**

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

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**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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**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.**

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**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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**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?

5. Please provide the age group that you serve, inclusive. \_\_\_\_\_

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**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, **please 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. \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_  
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