ENROLLMENT FOR CHILD AND ADULT CARE FOOD PROGRAM

New: _____ **Renewal:** ______ [*Sponsor Only:* ____ *PD* ____ *Free* ____ *Red.* ____ *Incomplete*]

Name of Child Care Center:	Bright Star Early Learning, LLC

Important: This form must be updated annually.

Name(s) of Enrolled Children: (Please print)	Days in Care (Check days that apply)							Meals Served (Check meals that apply)				
	M	TU	WE	TH	FR	SA	SU	Breakfast	AM Snack	Lunch	PM Snack	Supper
1. DOB: ____________ Time In: _____ Out: _____ Class: _______________												
2. DOB: ____________ Time In: _____ Out: _____ Class: _______________												
3. DOB: ____________ Time In: _____ Out: _____ Class: _______________												
4. DOB: ____________ Time In: _____ Out: _____ Class: _______________												
5. DOB: ____________ Time In: _____ Out: _____ Class: _______________												

_______________________________________ _______________________________________

Printed Name of Parent/Guardian Signature of Parent/Guardian

____

Date Signed

Phone Number of Parent/Guardian: ____________________

The Planning Council & MSDE Form

INFANT FEEDING PLAN (For children 0 - 12 mos.)

Center Name: Bright Star Early Learning, LLC

Address: 8301 Oakleigh Road

Dear Parent(s)/Legal Guardian(s):

This center/provider offers ______________________________ iron-fortified infant formula
Formula name
for all enrolled infants at no additional charge. It is your option whether or not to use this formula based on your preference and your infant's needs. All formula that is provided to infants at this facility must be iron-fortified as required by the Child and Adult Care Food Program.

PARENT FORMULA REQUEST

Please check one of the following options, **regarding FORMULA:**

_______ I will provide expressed breast milk for my infant. I understand that the breast milk I supply must be labeled with my child's name and the date the milk was expressed.

_______ I will use the infant formula offered by this facility.

_______ I ***will not*** use the infant formula offered by the facility. I will supply the following Infant formula for my infant ______________________________ .
Formula name

I understand that I must supply sufficient infant formula each day to meet my child's needs. Bottles must be labeled with my child's name and be dated. Bottles must be taken home daily.

PARENT FOOD REQUEST

When your infant is developmentally ready to eat solid foods, do you accept or decline the provider/facility-supplied food?

Please check one of the following options, **regarding FOODS:**

_______ I will supply all supplemental foods for my infant. [*Center may not claim my child for meals*]

_______ I will **ACCEPT** the supplemental foods offered to my infant(s) by this facility.

Child's Name: ______________________________

Child's Date of Birth: ______________________________

______________________________ ______________
Signature of Parent/Legal Guardian Date

All food and beverages served to infants in this facility must be in compliance with the infant meal pattern required by the Child and Adult Care Food Program.

BRIGHT STAR - OAKLEIGH

Meal Benefit Application for Child Care Centers

July 1, 2018 - June 30, 2019

For more information, read **Instructions for Completing** or call: 1-800-427-2888

Step 1 — **List all enrolled children (if more spaces are required for additional names, attach another sheet of paper).**

Children in **Foster Care** and children who meet the definition of **Homeless, Migrant, Runaway, Head Start, Early Head Start or Even Start** are eligible for free meals. If **ALL** children listed are foster, homeless, migrant, runaway or in Head Start, Early Head Start or Even Start, skip to Step 4.

First and Last Names of All ENROLLED	Check all that apply:					
	Foster Child	Homeless	Migrant	Runaway	Head Start Early Head Start	Even Start

Step 2 — **Do any Household Members (including you) currently participate in the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA)? Circle One: Yes No**

If you answered **NO**, complete Step 3.
If you answered **YES**, provide a case number then go to Step 4

Case Number: | | | | | | | | | |

Step 3 — **Report Income for ALL Household Members (skip this step if you answered 'Yes' to Step 2)**

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults): | | |

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: | | | | |

Check if No SSN: ☐

Step 4 — **Contact Information and Adult Signature**

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my child's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

Step 5 — **OPTIONAL: Children's Racial and Ethnic Identities**

We are required to ask for information about your children's race and ethnicity . This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Check one or more):
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $ ____________

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature: ____________________ Date: ____________

Date Withdrawn: ____________________