Admission Information

Use this form to collect all required information about a child enrolling in day care. The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the childcare facility.

Section 1 - General Information

Operation's Name:	Director's Name:

Child's Name	Child's Date of Birth	Child Lives With
		☐ Mom ☐ Dad ☐ Both Parents ☐ Guardian
Child's Home Address:		

Date of Admission:	Date of Withdrawal:

Name of Parent or Guardian Completing Form (Parent/Guardian 1)	Address of Parent or Guardian (if different from the child's)
Phone Number:	Email Address:

Parent/Guardian 2	Address of Parent/Guardian 2 (if different from the child's)
Phone Number:	Email Address:

Custody Documents on File ☐ YES ☐ NO

In case of an emergency, when the parent or guardian cannot be reached, call:

Name:	Relationship:

Phone number:

Street Address, City, State, and Zip Code

I authorize the childcare operation **to release** my child to leave the childcare operation **ONLY** with the following persons. Please list the name, relation, and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.

Name	Relationship	Phone Number

Section 2 – Consent Information

1. Transportation

I give consent for my child to be transported and supervised by the operation's employees. Check all that apply.

☐ For emergency care ☐ On field trips ☐ To and from home ☐ To and from school

2. Field Trips

◯ I give consent for my child to participate in field trips.

◯ I do not give consent for my child to participate in field trips.

Comments

3. Water Activities

I give consent for my child to participate in the following water activities. Check all that apply.

☐ Water table play ☐ Sprinkler play ☐ Wading pools ☐ Swimming pools ☐ Aquatic playgrounds

1. Is your child a competent swimmer? ◯ Yes ◯ No If no, your child is required to wear a life jacket while in or near a swimming pool.

2. Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming? ◯ Yes ◯ No

If yes, your child is required to wear a life jacket while in or near a swimming pool.

Note: A competent swimmer can enter and exit a pool safely on their own, tread water or float on their back for one minute, and swim 25 yards with no assistance.

4. Receipt of Written Operational Policies

I acknowledge receipt of the facility's operational policies, including those for the following. Check all that apply.

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Procedures for parents to participate in activities
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline and CCR website

5. Meals

I understand the following meals will be served to my child while in care. Check all that apply.

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care

My child is normally in care on the following days and times.

Day of Week	A.M.	P.M.	Day of Week	A.M.	P.M.
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

7. Receipt of Parent's Rights

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Parent or Legal Guardian Signature **Date Signed**

8. Child's Special Care Needs

Check all that apply.

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations in the past 12 months
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment, include instructions below
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above.

Does your child have diagnosed food allergies? ◯ Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at 800 514-0301 (voice) or 800 514-0383 (TTY).

Parent or Legal Guardian Signature **Date Signed**

9. School-Age Children

My child attends the following school	School Area Code and Phone No.

My child has permission to: ☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of their sibling younger than 18 years old

Authorized pick up or drop off locations other than the child's address.

☐ Child's required immunizations, vision and hearing screening are current and on file at their school.

Section 3 – Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Area Code and Phone No.

Street Address, City, State and ZIP Code

Name of Emergency Care Facility	Area Code and Phone No.

Street Address, City, State and ZIP Code

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Parent or Legal Guardian Signature **Date Signed**

Section 4 – Requirements for Exclusion from Compliance

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Health and Safety Code Section 161.0041 submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Section 5 – Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯ Pass ◯ Fail

Signature **Date Signed**

Section 6 – Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right:				◯ Pass ◯ Fail
Left:				◯ Pass ◯ Fail

Signature **Date Signed**

Section 7 – Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find they are able to take part in the day care program.

◯ A signed and dated copy of a health care professional's statement is attached.

◯ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

◯ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

If selected, Health Care Professional Name

If selected, Health Care Professional Street Address, City, State and ZIP Code

Health Care Professional Signature **Date Signed**

Parent or Legal Guardian Signature **Date Signed**

Section 8 – Vaccine Information

The following vaccines require multiple doses over time. Provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1 – 2 months (second dose)	
	6 – 18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15 – 18 months (fourth dose)	
	4 – 6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12 – 15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12 – 15 months (fourth dose)	

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6 –18 months (third dose)	
	4 – 6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12 – 15 months (first dose)	
	4 – 6 years (second dose)	
Varicella	12 – 15 months (first dose)	
	4 – 6 years (second dose)	
Hepatitis A	12 – 23 months (first dose)	
	The second dose should be given six to 18 months after the first dose.	

Section 9 – Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above.

Signature **Date Signed**

Section 10 – Varicella for Chickenpox

Varicella, the vaccine for chickenpox, is not required if your child has had chickenpox disease. If your child has had chickenpox, complete the statement: My child had varicella disease, chickenpox, on or about [date] and does not need varicella vaccine.

Signature **Date Signed**

Section 11 – Additional Information About Immunizations

For more information about immunizations, visit the Texas Department of State Health Services website at https://www.dshs.texas.gov/immunizations/public.

Section 12 – Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Section 13 – Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at https://hhs.texas.gov/policies-practices-privacy#security

Section 14 – Signatures

Child's Parent or Legal Guardian Signature **Date Signed**

Center Designee Signature **Date Signed**

Child Health Statement

Doctor office's may use their own form or this form)

Doctor's may email their form to info@lifeacademyschools.com

This is to certify that I have examined _____ (print child's name) on _____ (date), and found him/her to be healthy, free of contagious disease and able to participate in school/daycare activities.

Health care professional

_____

Signature of health care professional

_____

Date

*Form does not need to be completed if the Admission Requirement Section on Page 3 of the Admission Information Form is completed and signed by a doctor.

Enrollment Contract

Please complete a separate form for each child in the family.

Please initial each line next to each policy below to signify you have read and agree to our terms in this contract.

——— Childcare services will be provided by LIFE Academy for _____ (enter your child's name) on Monday through Friday. From _____to _____beginning on_____. Please remember that the days you select are your contracted days.

——— The following will be paid holidays: New Year's Day, Martin Luther King Day, Memorial Day, Juneteenth, 4th of July, Labor Day, Thanksgiving Day, the day after Thanksgiving, ½ Day Christmas Eve, Christmas Day, and the Day after Christmas. There will be no reduction in tuition for these holidays due to them being paid holiday for our staff and are such considered attendance days. Holidays that fall on Saturday will be observed on the preceding Friday, and holidays that fall on Sunday will be observed on the following Monday. No childcare service will be provided.

——— The fee for childcare will be $_____ weekly. Tuition is due on Friday before the following week of service being provided. A $50 late payment convenience fee will be added if the account is not paid by the close of business on Monday. Failure to pay on time may result in termination of services. No account will ever be allowed to carry a balance unless the Director has approved arrangements. Fees for two weeks will be added if a two-week written notice is not given before your child leaves the center. Clients may pay by cash, debit or credit card, and money order. Make all money orders payable to LIFE Academy. Please be advised that all debit and credit card payments will incur a surcharge.

——— The parent agrees to pay an enrollment fee of $75.00 payable at the time of application. Parent understands the enrollment fee is nonrefundable. If you withdraw your child for longer than 30 days, a new enrollment fee will be charged. This fee is an annual fee.

——— The parent agrees to pay childcare fees to hold a child's position when a child is absent. Absences include extended leave due to illness, vacation, etc. Full payment must be received whether child/children attend to reserve this space.

——— The parent agrees to provide a two-week notice of termination of the Childcare Contract. The parent agrees that the final two weeks' fees will be payable to LIEF Academy if two weeks' notice is not given to LIFE Academy before the child's withdrawal from LIFE ACADEMY. LIFE ACADEMY has the right to terminate a contract without notice in the case of a child causing harm to other children or a dangerous situation said child had caused intentionally or otherwise. An example of an extreme case is

when a child becomes a bitter, and all measures to stop the behavior have failed. This is rare, and LIFE ACADEMY will attempt to work with the parent and child to resolve any dangerous behaviors long before termination of the contract becomes necessary.

—— The parent agrees to complete all forms required given by LIFE ACADEMY. The parent agrees to update personal information as it occurs. The parent understands that their child cannot remain in care without proper documentation on file.

—— The parent agrees to provide all supplies requested by LIFE Academy. The parent understands that if required items are not supplied, they will be purchased by LIFE ACADEMY, and the parent will reimburse the provider for the total cost.

—— The parent agrees to sign their child/children in and out every day. Furthermore, please check if there are any important notes or your child's art in their cubby. We sometimes put important documents in there, and they often get forgotten about. We also need you to check to see if they have soiled clothing in their cubbies. I hold my employees to high standards to help keep the facility clean and leaving soiled clothes behind leaves odors to linger in the building.

—— I urge you to thoroughly read the contract and realize that it is legal and binding. You will be held liable for each of the initialed lines in this contract. By signing this agreement, you are accepting it and all its terms.

Parent's Signature: _____ Date: _____

Staff's Name: _____ Date: _____

Photo Consent Form

I, _____, the parent or legal guardian of _____ ☐grant ☐do not grant LIFE Academy permission to use photos or videos of my child, and agree to the following:

I understand that my child, whose name is listed above, may be photographed, or videoed at the center during normal daycare hours, field trips or activities. I understand that these photographs or videos may be used in promoting childcare services in either print or on the Internet.

With my signature below I grant permission for my child to be photographed, or their images recorded for print or electronic use in promoting the Center's services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

_____

Child's NAME

_____

PARENT/GUARDIAN NAME

_____

PARENT/GUARDIAN SIGNATURE

_____

DATE

Topical Ointment and Cream Authorization

Child's Name: _____ DOB: _____

Authorization form for the application of non-prescription topical ointment or cream, including but not limited to sunscreen, insect repellent, diaper ointment, or teething gel.

I understand that the topical ointment provided by me must:

- ✓ be appropriate for use on a child.
- ✓ be applied according to instructions on the label.
- ✓ be labeled with the child's full name.

I authorize LIFE Academy staff to apply the following non-prescription topical ointment or cream to my child, as described below:

- Sunscreen
  - Product Name: _____
- Insect Repellent
  - Product Name: _____
- Non-Prescription ointment (such as Diaper Cream)
  - Product Name: _____
- Other (Please specify)
  - Product Name: _____
  - Product Name: _____

This authorization is valid for one year. Upon expiration, place in child's file.

_____

Parent/Guardian Signature Date

Allergy Emergency Plan

This plan must be signed and dated by your child's Health Care Professional

Child's Name: _____Date of Birth: _____

Doctor: _____

Address: _____

Phone: Fax: _____

Please complete one form for EACH known Allergy

Child is allergic to: _____

Possible Symptoms if exposed to this allergy:

_____

_____

_____

Specific steps to take if the child has an allergic reaction:

:_____

_____

_____

By signing below, the parent or guardian of this child gives Early Care and Education permission to post the child's food allergy in the food serving and food preparation areas.

Dr Signature: _____ Date: _____

Parent or Guardian Signature: _____Date: _____

Center Director Signature: _____ Date: _____

For licensed center use:

_____ Food Allergy Emergency Plan has been posted in the classroom and food service area

_____ Food Allergy Emergency Plan has been posted in the food preparation area

_____ Food Allergy Emergency Plan has been included in your emergency evacuation binder

_____ Food Allergy Emergency Plan has been included in your field trip and transportation binder

Infant Care Instructions

The Texas Health and Human Service Commission (THHSC) requires that parents provide feeding instructions for children not yet ready for table food. **These instructions must be reviewed and updated every 30 days until the child is 12 months of age.**

Child's Name: _____ DOB: _____

☐ I will bring expressed breast milk for my infant.

☐ I want the childcare provider to provide the infant formula it offers for my infant.

☐ I will bring the infant formula for my infant. Please list the kind of infant formula you will bring:

_____

☐ Feed on demand ☐ Schedule:

_____ oz at _____

_____ oz at _____

_____ oz at _____

_____ oz at _____

_____ oz at _____

_____ oz at _____

Bottled warmed? ☐ Yes ☐ No

Baby Food:

☐ My child is developmentally ready for solid foods. I want the childcare provider to provide the infant cereal and other foods for my infant.

☐ My child is developmentally ready for solids. I will bring the infant cereal and/or other foods for my infant.

☐ My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.

☐ Feed on demand ☐ Schedule:

Breakfast: _____ at _____

Lunch: _____ at _____

Required to update every 30 days until 12 months of age.
Please request a form from the teacher or retrieve one from our website. If there aren't any changes sign and date the current form.
8/2023

Snack: _____ at _____

Other instructions:

_____

_____

Does your child have any allergies? ☐ Yes ☐ No If yes, symptoms:

_____

_____

***Provide the office with an allergy plan if your child has any allergies.**

Does your child use a pacifier? ☐ Yes ☐ No

Your child will not be administered any type of diaper ointment without your written consent. You will need to provide ointment, lotion, or creams to use, if requested.

Lotion _____ Ointment _____ Other _____

Sleeping Instructions

☐ On demand ☐ Schedule:

Nap times: _____

THHSC states that infants not yet able to turn over on their own must sleep on their back unless the child's parent presents written documentation from a health-care professional stating that a different sleeping position is allowed or will not harm the infant.

Any other information we should know?

_____

_____

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Required to update every 30 days until 12 months of age.
Please request a form from the teacher or retrieve one from our website. If there aren't any changes sign and date the current form.
8/2023

TEXAS Health and Human Services

Form 2550
September 2023

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards Sections 746.501(9) and 747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at LIFE Academy and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Safe Sleep Policy

All staff, substitute staff, and volunteers at LIFE Academy will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [Sections 746.2427 and 747.2327].
- Place infants on a firm mattress, with a tight-fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non full-size cribs [Sections 746.2409 and 747.2309].
- For infants who are younger than 12 months old, cribs play yards should be bare except for a tight-fitting sheet and a mattress cover or protector. Items that should not be placed in a crib or play yard include: soft or loose bedding, such as blankets, quilts or comforters; pillows; stuffed toys and animals; soft objects; bumper pads; liners; or sleep positioning devices [Sections 746.2415(b) and 747.2315(b)]. Also, infants must not have their heads, faces or cribs covered at any time by items such as blankets, linens, or clothing [Sections 746.2429 and 747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [Sections 746.2415(b) and 747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [Sections 746.3407(10) and 747.3203(10)].
- If an infant needs extra warmth, use sleep clothing _____ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [Sections 746.2415(b) and 747.2315(b)].
- Place only one infant in a crib to sleep [Sections 746.2405 and 747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [Sections 746.2415(b) and 747.2315(b)] or the infant’s clothing by a string, cord or other attaching mechanism that might be a suffocation or strangulation risk [Sections 746.2401(6) and 747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [Sections 746.2426 and 747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [Sections 746.3703(d) and 747.3503(d)].
- Actively observe sleeping infants by sight and sound [Sections 746.2403 and 747.2303].
- If an infant can roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [Sections 746.2427 and 747.2327].
- Awake infants will have supervised “tummy time” several times daily. This will help them strengthen their muscles and develop normally [Sections 746.2427 and 747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant’s health care professional [Sections 746.2428 and 747.2328].

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

Signatures

This policy is effective on: _____ Child's name: _____

_____ _____
Signature — Director or Owner Date Signed

_____ _____
Signature — Staff member Date Signed

_____ _____
Signature — Parent Date Signed

FP Assistance
Feeding the Future

Enrollment Form

Center Name: _____ Site Code: _____

Child's Name: _____ Date of Birth: ____/____/____

Admission date: ____/____/____ Withdrawal Date: ___/____/____ Classroom: _____

1. Circle the days that your child will <u>normally</u> attend the center:

Mon Tue Wed Thu Fri Sat Sun

2. Circle the meals <u>normally</u> served to your child in the center:

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

3. What hours will your child <u>normally</u> be in the center:

____:_____ to ____:_____

4. Participant's ethnic and racial identities

Ethnicity (choose one ethnic identity):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: (choose one or more racial identities):

☐ Asian ☐ American Indian or Alaska Native
☐ White ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American

	Parent Signature	Date of Signature	Day Time Phone Number
1)	_____	_____	(____) ____-____
2)	_____	_____	(____) ____-____
3)	_____	_____	(____) ____-____
4)	_____	_____	(____) ____-____

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions if your household receives SNAP, TANF, or FDPIR benefits:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP, TANF, or FDPIR benefits. The SNAP or TANF number must be the 8 or 9-digit EDG# assigned by HHSC. **For Day Care Home Providers seeking Tier I classification only:** You must provide additional dated documentation supporting participation in these programs.

Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

Follow these instructions if you are a Day Care Home Provider or have a child enrolled at a Day Care Home Provider, *and* your child or a household member is enrolled in any of the federal or state qualifying Programs listed in Form H1660, *List of Eligible Federal/State Funded Programs*:

Part 1: List all enrolled children and household members.
Part 2: Skip this part.
Part 3: The sponsor should have provided Form H1660, *List of Eligible Federal/State Funded Programs* with this application. Provide the name of the qualifying Program from Form H1660 and list the eligibility number, if applicable. **In order to qualify a child without providing income information in Part 4**, you must additionally attach official evidence of the household's participation in the listed program.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

Follow these instructions If all children you are applying for are foster or homeless children, or if you are only applying for benefits for the foster or homeless child:

Part 1: List all foster or homeless children**.** Check the box indicating that the child is a foster or homeless child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Adult household member must sign the form. The last four digits of the Social Security Number are not required.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

All other households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster or homeless child.
Part 2: Skip this part. See instructions above for households participating in SNAP, TANF, or FDPIR.

Part 3: Skip this part. See instructions above for households participating in a qualifying program listed in Form H1660.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub, or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Name of Child Care Facility or Day Care Home Provider:

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) OR A HOMELESS CHILD * IF ALL CHILDREN LISTED BELOW ARE FOSTER OR HOMELESS CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR benefits, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to Part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home or day care home provider households) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660),* provide the name of the program and eligibility number:

NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

ADDITONALLY, PLEASE ATTACH OFFICIAL EVIDENCE OF ENROLLMENT IN THE LISTED PROGRAM. If you are not a day care home provider, do not have a child enrolled at a day care, and/or are not participating in a qualifying program, **skip to Part 4**.

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand tha t if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

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

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meal benefits. You must include the last four digits of the Social Security Number of the adult household member who signs the application; however, the Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR), or other qualifying program eligibility identifier, or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

AUTOMATED PAYMENT PROCESSING AUTHORIZATION

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from your debit or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR DEBIT and CREDIT CARD

I (we) hereby authorize (business name) LIFE ACADEMY to initiate debit or credit card charges to the below-referenced debit or credit card account indicated below

To properly affect the cancellation of this agreement, I (we) are required to give 10-day written notice.

Check with the center for accepted credit card types.

Debit or Credit Card:

Cardholder Name: _____ Phone #: _____

Card number: _____ - _____-_____-_____ Expiration Date: _____

Cardholder Address:

_____

City: _____ State: _____ Zip: _____

Cardholder Signature: _____ Date: _____

Tuition Express®

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Date Received: _____

Employee Signature: _____

8/2021