105 Mill RD
Irvington, NJ 07111 ( )
862-872-3646

( ) 1211 Springfield Ave
Irvington, NJ 07111
862-233-7866

( )Yearly Enrollment

( ) Short Term Enrollment

( )Summer Enrichment Program

Application Receipt- Keep this front page for yourself!

I submitted this application on: _____at_____:_____am/pm

I submitted my application to:_____

Dropoff & Dismissal Time (pick-up)

Morning Cut Off Time	Monday thru Thursday	Friday
10:00 A.M. No Exception	6:30 a.m.- 5:45 p.m.	6:30 a.m. - 5:30 p.m.

KCCA collects information in order to best serve the needs of our scholars and families.

For Office Use

Age Range:

0-18 ( ) 3 ½ - 4 ( )
18 ½ - 2 ( ) 5 - 9 ( )
2 ½ - 3 ( ) 10 - 13 ( )

Returner?
( ) Yes ( ) No

Orientation Date:

Received by:	Received on:
Entered by:	Entered on:

Complete **Incomplete**

	Completed, Signed and Dated Application	
	Copy of Birth Certificate	
	Copy of Insurance Card	
	Universal Child Health Record (Physical)	
	Up to Date Immunization Records	
	Emergency Medical Authorization Form	
	Allergy Form/Asthma Action/Seizure/Diabetes (If Applicable)	
	Infant Feeding Plan (If Applicable)	
	Emergency Form (including pickup/cannot pickup)	
	Expulsion Policy	
	Communication Policy	
	Photo/Video Release Form	
	Walking Permission Slip & Water Play Permission Slip	
	Copy of Parent Photo Identification ID/Passport	
	Brightwheel Acknowledgment	
	Lunch Application	
	Registration Fee $100	

Parent Initial _____

HOUSEHOLD INFORMATION

Address:		Apartment/Floor
City:	State:	Zip:

Scholar's Information

Name:	Female ( ) Male ( )	Date ofBirth ____/____/_____
Parent/Guardian Number (____)_____-_____ [C__M__W__] Email _____@_____._____		0-18__18 ½ - 2__ 2 ½ - 3__4 -5__ Grade Below for Summer Camp K__1__2__4__4__5__6__7__
Does scholar have an IEP ( ) Yes ( ) No Does scholar have an 504 ( ) Yes ( ) No If Yes, what are the modifications? Please include copy		<u>*Check if apply*</u> Pamper/Pull-up___Potty Train___ Meal Plan _____ Scheduled Medication _____
Will scholars participate in receiving free meals at school? ( ) Yes ( ) No Please inform the school if any change. School is free of NUTS, EGGS & SEAFOOD		Are there any activities scholar cannot participate in ( ) Yes ( ) No
Allergies (check all if apply) __Peanuts __Shellfish __Treenut __Milk __Egg __Soy __Fish __Other (please write in medical details)	Medical (check all if apply) __Asthma __Diabetes __Seziure Disorder __ADD __ADHD __Other (please write in medical details)	Language Spoken __English __Spanish __French __Portuguess __Chinese __Hindi

Parent Initial _____

List all medical details: _____ _____ __

Parent/Guardian Information

Name: _____ _____	Email _____@_____.____		
Address:	City	State	Zip
Phone: ( ) _____-_____	Work ( ) _____- _____ ex:___		
Relationship o scholar: ( ) Mother ( ) Father ( ) Sister ( ) Brother ( ) Grandparent ( ) Aunt ( ) Uncle	Best contact time: ( ) Morning ( ) Noon ( ) Evening		
Employer: _____ _____ _	Address: _____ _____ _	City/State _____,____ _	

Parent Initial _____

Parent signature: _____ Date: _____/_____/_____

Kiddie College Campus Academy

Photo/Video Release Form

As the parent of a child/children at Kiddie College Campus Academy, I agree to the following:

- I understand that my child(ren) whose name(s) are listed below may be photographed at Kiddie College Campus Academy during normal daycare hours, field trips or activities.
- I understand that these photographs/videos may be used in school newsletters or posted on the Kiddie College Campus Academy website, Facebook, or any other publication.
- I give permission for my child(ren)'s photographs/videos to be posted on Kiddie College Campus Academy website, Facebook, newsletters, or any other publication. (When names are added, only first names will be used.)
- I understand that I have the right to request, in writing, to have a photo removed from the website or Facebook within 30 workdays.

  The Following are the names of my child(ren) attending Kiddie College Campus Academy: _____

  _____

( ) Yes, I confirm that I have read and understood the above, and agree to have my child(ren)'s photos mounted on the Quality Time Child Care and Preschool website, Facebook page, newsletters or any other publication.

( ) No, I do not wish to have my child(ren)'s photographs published.

Name (please print) _____

Signature:_____

Date:_____

Pickup List

Name	Address	Phone	Relationship

No Pickup List

Name	Address	Relationship	Order of Protection / Reason

If there's a court order we will need a copy for our record.

Parent Initial _____

105 Mill RD
Irvington, NJ 07111 ( )
862-872-3646

( ) 1211 Springfield Ave
Irvington, NJ 07111
862-233-7866

Walking Permission Slip

(Child's Name) _____is allowed _____is not _____ to participate in spontaneous, walking field trips throughout the year. I understand that each trip will take place in the area, weather permitting, and the teachers will always accompany the children.

Parent _____

Date _____

Phone Number _____

105 Mill RD
Irvington, NJ 07111 ( )
862-872-3646

( ) 1211 Springfield Ave
Irvington, NJ 07111
862-233-7866

WATER PLAY PERMISSION FORM

I hereby give permission for my child, _____, to participate in water play (sprinklers, water splash etc.) in the playground or other designated area at the school during the summer year 2020 he/she attends the school. I understand that my child's care provider will:

• Maintain a safe staff to child ratio while participating in water activities

• Closely monitor my child and will never leave them unattended while they are participating in the water activities listed below.

Parent/Guardian Signature _____

Date _____

Phone Number _____

Medical Treatment Release Form

In any event that a medical emergency occurs, I authorize Kiddie College Campus Academy to seek emergency medical care for my child as deemed necessary by staff members of Kiddie College Campus Academy.

I give permission for my child, _____, to be given first aid and emergency treatment by certified Kiddie College Campus Academy staff. I acknowledge that no guarantees have been made as to the results of such treatment.

Parent's Name (print) _____

Parent's Signature_____

Date_____

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: ____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Infant Feeding Plan

A written plan shall be maintained on file and available for the caregiver of any child less than 12 months of age.

Child's Name:	Date:	Birthdate:

Formula:

☐No ☐Yes Is your child fed formula[1]?

☐No ☐Yes Will formula be prepared (mixed) at home?

☐No ☐Yes Will formula be prepared by the caregiver?

If the caregiver will be preparing the formula, please indicate any special instructions:

_____

Breast Feeding/Breastmilk

☐No ☐Yes Is your child breast fed?

☐No ☐Yes I will nurse my child at the center at these times:

_____

☐No ☐Yes I will provide breast milk[1].

If breast milk is unavailable for a feeding, the center should:

_____

Feedings:

☐No ☐Yes Does your child take a bottle? (Note: Bottles are required to be labeled with child's name and the current date.)

- ☐No ☐Yes Is the bottle warmed[2]?
- ☐No ☐Yes Does your child hold their bottle?
- ☐No ☐Yes Can the child feed his or herself?
- ☐No ☐Yes Are there any special instructions for bottle feeding your child?

If "yes," please explain:

_____

☐No ☐Yes Is your child using a sippy cup? (Note: Sippy cups must be labeled with the child's name.)

☐No ☐Yes Does your child have any problems with feeding, such as choking or spitting up?

If "yes," please explain:

_____

☐No ☐Yes Are there any special instructions concerning feeding your child?

If "yes," please explain:

_____

Foods and Feeding Schedule:

Liquids (formula, breastmilk, 100% fruit juice in a cup)	☐N/A ☐Introducing ☐Familiar	☐Breast Feeding ☐by bottle ☐by breast ☐Bottle Feeding ☐by caregiver ☐with help ☐independently ☐Cup Feeding ☐with help ☐independently		Amounts:
Semisolid Foods (infant cereal, strained fruits and/or vegetables)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:
Modified Table Foods (mashed, soft, diced fruit and /or vegetables, strained meat or poultry, pieces of soft bread)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:
Finger Foods (small pieces of soft/cooked table food, chopped food)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:

Other:

☐No ☐Yes Does your child take a pacifier?

Note: Pacifiers with straps or other types of attachment devices are not permitted. Pacifiers must be removed when the child is crawling or walking.

Additional Information:

I will promptly provide any updates to my child's feeding plan as needed.	PARENT'S SIGNATURE:	DATE:

[1]Breast milk shall be gently mixed but not be shaken. Refrigerated breast milk shall be used within 24 hours. Formula or breast milk that is served, but not completely consumed or refrigerated, shall be discarded. [2] No milk, formula, or breast milk shall be warmed in a microwave oven.

Daily updates

Real-time feed of activities throughout the day.

Photos

Watch your child’s day unfold with snapshots delivered to your mobile device.

Stay connected

Stay in touch with your teacher and strengthen school learning with activities at home.

Digital check-in

Easy digital check-in with personal passcodes. Add approved adults to pick up your child, and see when your child is checked in or ou

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Name Of Child:	Birthdate:	Enrollment Date:

PARENT/GUARDIAN INFORMATION

	☐ PARENT/GUARDIAN # 1		☐ PARENT/GUARDIAN # 2
Name:		Name:	
Relationship:		Relationship:	
Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:	
Home Address:		Home Address :	
Employer Name:		Employer Name:	
Employer Phone:		Employer Phone:	
E-Mail Address:		E-Mail Address:	

EMERGENCY CONTACTS

Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.					
Contact Name #1:		Contact Name #2:		Contact Name #3:	
Relationship:		Relationship:		Relationship:	
Cell Phone:		Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:		Home Phone:	
Employer Phone:		Employer Phone:		Employer Phone:	

CUSTODY

Name of person PROHIBITED from picking up your child:	
If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order.	

MEDICAL INFORMATION

Child's Health Care Provider:	
Health Care Provider Phone:	
Health Care Provider Address:	
Name Of Insurance Company/Hmo:	
Group #:	
Identification #:	
Subscriber's Name On Insurance Card:	
Known Allergies (including medication):	
Medication My Child Is Taking:	
List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations:	

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Signature #1:	Date:	Parent/Guardian Signature #2:	Date:

Parent Information
(PLEASE KEEP FOR YOUR RECORD)

Policy on the Management of Communicable Diseases

If a child exhibits any of the following symptoms, the child should not attend the center. If such symptoms occur at the center, the child will be removed from the group, and parents will be called to take the child home.

- **Severe pain or discomfort**
- **Acute diarrhea**
- **Episodes of acute vomiting**
- **Elevated oral temperature of 101.5 degrees Fahrenheit**
- **Lethargy**
- **Severe coughing**
- **Yellow eyes or jaundiced skin**
- **Red eyes with discharge**
- **Infected, untreated skin patches**
- **Difficult or rapid breathing**
- **Skin rashes in conjunction with fever or behavior changes**
- **Skin lesions that are weeping or bleeding**
- **Mouth sores with drooling**
- **Stiff neck**

Once the child is symptom-free, or has a health care provider's note stating that the child no longer poses a serious health risk to himself/herself or others, the child may return to the center unless contraindicated by the local health department or Department of Health.

EXCLUDABLE COMMUNICABLE DISEASES

A child or staff member who contracts an excludable communicable disease may not return to the center without a health care provider's note stating that the child presents no risk to himself/herself or others.

Note: If a child has chicken pox, a note from the parent stating that all sores have dried and crusted is required.
If a child is exposed to any excludable disease at the center, parents will be notified in writing.

COMMUNICABLE DISEASE REPORTING GUIDELINES

Some excludable communicable diseases must be reported to the health department by the center. The Department of Health's Reporting Requirements for Communicable Diseases and Work-Related Conditions Quick Reference Guide, a complete list of reportable excludable communicable diseases, can be found at:

http://www.nj.gov/health/cd/documents/reportable_disease_magnet.pdf

COMMUNICATION POLICY

Parent/Teacher/School Communication Policy

What parents can <u>EXPECT</u>

- Parent communications responded to within a reasonable time
- Requests for appointments responded to or scheduled within a reasonable time
- Parent to be notified about single serious issue or ongoing problem
- Two formal conferences per year, other meetings and calls within reason

What parents should <u>NOT EXPECT</u>

- Teachers returning a call after work hours
- Answering email in the evening/weekends
- Access to teacher's private phone number or email

When you should contact your child's teacher:

- Changes in family situation (any emergency: family, move, etc.)
- Medical issues that arise or change
- Illness lasting longer than 3 days
- Safety issues, change in behavior at home
- Family emergencies, sleepless nights, play dates, appointments (send a note)
- Ongoing and pervasive problems/concerns at school or home
- When you can't keep a scheduled appointment
- When homework takes way more time than expected, or your child is unable to do most of it independently

When you have last minute information for the teacher:

- Send a note
- Call the office and leave a message for the teacher

Communication that interferes with teaching and learning:

- Showing up at the classroom during the teacher's instructional time during the school day without an appointment

- Discussing an issue with the teacher when they come out to pick up their class in the morning and it's time for instruction to start
- Speaking to any teacher/staff in a disrespectful manner.
- Gossiping to other parents rather than discussing issues directly with the Director and staff members. Remember that you are a model of how you want your child to communicate.

Ways to help your child be more responsible and independent:

- Encourage your child to talk to the teacher about problems with homework or other issues at school. Send an email or note to the teacher so they're aware, for example, "Joe had a problem in the yard yesterday that he needs to talk to you about." Let the teacher take it from there.
- Have your child write a note to the teacher explaining why homework wasn't completed, then sign the note. This is a requirement in upper grade rooms.
- Make your child responsible for carrying their own backpack and belongings to and from school – Preschoolers!
- If your child is late, bring them to the office to check-in. In the case of Pre- Kindergarten students, walk them from the office to the classroom door.

EXPULSION POLICY

Unfortunately, there are sometimes reasons we have to expel a child from our program either on a short term or permanent basis. We want you to know we will do everything possible to work with the family of the child(ren) in order to prevent this policy from being enforced.

The following are reasons we may have to expel or suspend a child from this center:

IMMEDIATE CAUSES FOR EXPULSION:
• The child is at risk of causing serious injury to other children or himself/herself.
*Parents threaten physical or intimidating actions toward staff members.
• Parent exhibits verbal abuse to staff in front of enrolled children

PARENTAL ACTIONS FOR CHILD'S EXPULSION:
• Failure to pay/habitual lateness in payments.
• Failure to complete required forms including the child's immunization records.
• Habitual tardiness when picking up your child.
• Verbal abuse to staff.
• Other (explain)

CHILD'S ACTIONS FOR EXPULSION:
• Failure of child to adjust after a reasonable amount of time.
• Uncontrollable tantrums/ angry outbursts.
• Ongoing physical or verbal abuse to staff or other children.
• Excessive biting.
• Other (explain)

SCHEDULE OF EXPULSION:
If after the remedial actions above have not worked, the child's parent/guardian will be advised verbally and in writing about the child's or parent's behavior warranting an expulsion. An expulsion action is meant to be for a period of time so that the parent/ guardian may work on the child's behavior or to come to an agreement with the center. The parent/guardian will be informed regarding the length of the expulsion period and the expected behavioral changes required in order for the child or parent to return to the center. The parent/guardian will be given a specific expulsion date that allows the parent sufficient time to seek alternate child care (approximately one to two weeks' notice depending on risk to other children's welfare or safety). Failure of the child/parent to satisfy the terms of the plan may result in permanent expulsion from the center.

A CHILD WILL NOT BE EXPELLED IF A PARENT/GUARDIAN:
• Made a complaint to the Office of Licensing regarding a center's alleged violations of the licensing requirements.

• Reported abuse or neglect occurring at the center.
• Questioned the center regarding policies and procedures.
• Without giving the parent sufficient time to make other child care arrangements.

PROACTIVE ACTIONS THAT CAN BE TAKEN IN ORDER TO PREVENT EXPULSION:

• Try to redirect children from negative behavior.
• Reassess classroom environment, appropriateness of activities, supervision.
• Always use positive methods and language while disciplining children.
• Praise appropriate behaviors.
• Consistently apply consequences for rules.
• Give the child verbal warnings.
• Give the child time to regain control.
• Document the child's disruptive behavior and maintain confidentiality.
• Give the parent/guardian written copies of the disruptive behavior that might lead to expulsion
• Schedule a conference including the director, classroom staff, and parent/guardian to discuss how to promote positive behaviors.
• Give the parent literature of other resources regarding methods of improving behavior.
• Recommend an evaluation by professional consultation on premises.
• Recommend an evaluation by the local school district study team.

PARENT
RECEIPT OF INFORMATION:

- ☐ Information to Parents Document
- ☐ Policy on the Release of Children
- ☐ Policy on Methods of Parental Notification
  (Applicable only if a method other than a phone call is used to notify parents of an injury to a child's head, a bite that breaks the skin, a fall from a height, or an injury requiring professional medical attention.)
- ☐ Policy on Communicable Disease Management
- ☐ Expulsion Policy
- ☐ Policy on the Use of Technology and Social Media

I have read and received a copy of the information/policies listed above.

Child(ren)'s Name: _____

Parent/Guardian's Name: _____

_____ _____

Signature Date

105 Mill RD
Irvington, NJ 07111
862-872-3646

1211 Springfield Ave
Irvington, NJ 07111
862-233-7866

Kiddie College Campus Academy 1 & 2
FINANCIAL INFORMATION

INSTRUCTIONAL TIME: (8:30 a.m. – 3:30 p.m.)
Last Drop-Off Time 9:35 a.m Last Pick-up 5:45
(School Breakfast Ends at 9:20 a.m.)
Before Care 6:30 a.m. - 8:00 a.m (105 Mill RD location ONLY))
After Care - 4:00 p.m. 5:45 p.m.

LATE FEE: $2.00 PER MIN if Scholar(s) is picked up after 5:45 p.m.

*NOTE: Parents can apply for the NJCK program under Programs for Parents; see the Director for assistance

Registration fees- A one time fee of $100.00 (Fee is Nonrefundable)

0 - 18 months - $325.00 PER WEEK

18 ½ months - 2 ½ YEARS $310.00 PER WEEK

3 - 6 YEARS $295.00 PER WEEK (Pre-K ONLY)

Before Care $85.00 Weekly
After Care $85.00 Weekly
Combo $170.00 weekly
**Summer Camp $225.00 PER WEEK* (field trip cost are a separate price)

Eligible parents who have Programs for Parents must carry their Family first swipe card for student check in and checkout daily. /Sick days and absences are also recorded and can be done as a back swipe (see Director for instruction)
All Co payments are due by the 2nd calendar day of each month any fees received thereafter will be deemed late and an additional $10.00 will be applied.
Any days in which the Parent forgets to swipe and does not complete back swipes within the given or allotted time, the parent will be responsible for the tuition for that date at the rate of the center's fees and not Programs for Parents daily rate due to loss of payment.

2025 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM
ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT(S) _____ _____ _____ _____
(Name) (Age) (Name) (Age)

***OPTIONAL**: RACIAL/ETHNIC IDENTITY OF PARTICIPANT*

Check one ETHNIC identity:

[ ] Hispanic or Latino [ ] Not Hispanic or Latino

Mark one or more RACIAL identity (ies):

[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American

[ ] Native Hawaiian or Other Pacific Islander [ ] White

Enrollment Information

***Check ( ) each day** the above participant is enrolled for care, the hours of care each day, and the meal type(s) served:*

DAYS OF CARE:	*MON*	*TUES*	*WED*	*THURS*	*FRI*	*SAT*	*SUN*
HOURS OF CARE:	-	-	-	-	-	-	-
Swing / Rotating Shifts: (If Applicable)	-	-	-	-	-	-	-

MEAL TYPES SERVED: ***BREAKFAST*** ***A.M. SUPPLEMENT*** ***LUNCH*** ***P.M. SUPPLEMENT*** ***SUPPER***

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP) (*formerly Food Stamps*), **Temporary Assistance for Needy Families (TANF)**, or **Food Distribution Program on Indian Reservations (FDPIR)**

If you are now receiving SNAP,TANF or FDPIR for this child, complete **one** of the following numbers:

SNAP CASE # _____ OR **TANF CASE #** _____ OR **FDPIR CASE #** _____

OPTION 1B: FOSTER CHILD

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

FOSTER CHILD **INCOME $** _____

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete one of the following numbers:

SNAP CASE # _____ OR **FDPIR CASE #** _____ OR **SSI CASE #** _____ OR **MEDICAID CASE #** _____

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: *(Related and Unrelated)*	**MONTHLY INCOME** *(Complete One Or More - Before Deductions)*				
	Monthly (Gross Earnings) Wages/Salary	MONTHLY SOCIAL SECURITY PENSIONS / RETIREMENT	MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION	MONTHLY WELFARE, CHILD SUPPORT, ALIMONY	Monthly Any Other Income
1	$	$	$	$	$
2	$	$	$	$	$
3	$	$	$	$	$
4	$	$	$	$	$
5	$	$	$	$	$
6	$	$	$	$	$
7	$	$	$	$	$
8	$	$	$	$	$
9	$	$	$	$	$
10	$	$	$	$	$

TOTAL NUMBER IN HOUSEHOLD *(INCLUDE ENROLLED PARTICIPANT)*: _____ $_____

TOTAL GROSS HOUSEHOLD INCOME: _____

ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: *(See Privacy Act Statement below)*
An Adult Household Member must sign and date this form, and list the last four (4) digits of his or her Social Security Number.
If you do not have a social security number, mark the box - ☐ "I do not have a Social Security Number."

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information, and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. ***An Adult Household Member must complete the following:***

Signature: _____ Address: _____

Print Name: _____ City: _____ State: _____ Zip Code: _____

Date: _____ Phone Number: _____

Last four (4) digits of Social Security Number: * * * - * * - _____ ☐ **I do not have a Social Security Number**

PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, and investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

Determination: Free: _____ Reduced: _____ Paid: _____

Signature of Determining Official:

_____ Date: _____

TOTAL MONTHLY INCOME $_____

Conversion factors to figure monthly income: Weekly x 4.33
Twice a month x 2
Every 2 weeks x 2.15

2024-2025 CHILD AND ADULT CARE FOOD PROGRAM LETTER TO PARENT/PARTICIPANT

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.

The income that you report must be the total gross income received by all members of your household.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced- priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.

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 (including gender identity and sexual orientation), 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. US Department of Agriculture, Office of the Assistant of Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250; or 2. Fax (833) 256-1665 or (202) 690-7442; or 3. Email: program.intake@usda.gov

(Name of Day Care Center)	*(Day Care Center Phone Number)*
New Jersey Department of Agriculture Child and Adult Care Food Program	***Phone Number 609-984-1250***

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant *(First and Last Names)*.
2. Complete the Days, Hours of Care, and the meal types served to the enrolled participant. *(One time requirement for Adult Day Care participants)*

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.

b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

1. Names of all *(Related or Unrelated)* household members
2. List the household income *(Monthly Gross Earnings)* for each household member.
3. Total number in household *(#1 + #3 above)*.
4. Total the gross income of all household members.
5. Sign, Print and complete the full address of the Adult Household Member signing the application.
6. Date the form and complete the telephone number of Adult Household Member signing the application.
7. List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE
Effective From July 1, 2024 to June 30, 2025

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	$19,579 - $27,861	$1,633 - $2,322	$ 378 - $ 536
2	$26,573 - $37,814	$2,216 - $3,152	$ 512 $ 728
3	$33,567 - $47,767	$2,799 - $3,981	$ 647 - $ 919
4	$40,561 - $57,720	$3,381 - $4,810	$ 781 - $1,110
5	$47,555 - $67,673	$3,964 - $5,640	$ 916 - $1,302
6	$54,549 - $77,626	$4,547 - $6,469	$1, 050 - $1,493
7	$61,543 - $87,579	$5,130 - $7,299	$1,185 - $1,685
8	$68,537 - $97,532	$5,713 - $8,128	$1,319 - $1,876
Each Additional Family Member	**+9,953**	**+830**	**+192**

Teaching children is an accomplishment; Getting children excited about school is an Achievement.

-Robert John Meehan

Thank You For Trusting In Us!!!!