Enrollment Agreement

Beyond the Spectrum LLC L

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

Enrollment Information

Child's Information

Child's first name	Child's middle name	Child's last name	Child's nickname
Age / Sex	Child's primary language	Parent/guardian/sponsor primary language	
Child's home address	City	State	Zip
Does your child attend school? ☐ Yes ☐ No	School name	Grade	School phone
School address	Drop off time	Pick up time	

Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings

Parent/guardian/sponsor	Relationship to child	Home phone	Cell phone		
Home address if different from above	City	State	Zip		
Home email	Work email	Work phone			
Employer	Employer address	City	State	Zip	Work hours
Other parent/guardian/sponsor	Relationship to child	Home phone	Cell phone		
Home address if different from above	City	State	Zip		
Home email	Work email	Work phone			
Employer	Employer address	City	State	Zip	Work hours

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day.
[For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.]

Person #1	Relationship to child	Home phone	Cell phone		
Home address	City	State	Zip		
Home email	Work email	Work Phone			
Employer	Employer address	City	State	Zip	Work hours
Person #2	Relationship to child	Home phone	Cell phone		
Home address	City	State	Zip		
Home email	Work email	Work Phone			
Employer	Employer address	City	State	Zip	Work hours
Person #3	Relationship to child	Home phone	Cell phone		
Home address	City	State	Zip		
Home email	Work email	Work Phone			
Employer	Employer address	City	State	Zip	Work hours

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial _____ Staff initial _____ Date _____

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Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color

Distinguishing marks

Child's Medical & Developmental History

1. Does your child have any special medical conditions? ☐ No ☐ Yes Explain
2. Does your child have any chronic illnesses? ☐ No ☐ Yes Explain
3. Please list a brief history of your child's serious injuries and hospitalizations.
4. Does your child have diabetes? ☐ No ☐ Yes *If yes, please attach care instructions from your physician.*
5. Does your child have asthma? ☐ No ☐ Yes *If yes, please attach care instructions from your physician.*
6. Will medication be administered regularly? ☐ No ☐ Yes *If yes, please attach care instructions from your physician.*
7. Does your child have any special dietary needs? ☐ No ☐ Yes Explain
8. Is your child able to fully participate in all activities? ☐ Yes ☐ No Explain
9. Does your child have any physical restrictions? ☐ No ☐ Yes Explain
10. Does your child function at the level of other children in his/her age group? ☐ Yes ☐ No Explain
11. Is your child able to walk ☐ Yes ☐ No
12. Can your child communicate his/her needs? ☐ Yes ☐ No
13. Does your child need assistance at meal time? ☐ No ☐ Yes Explain
14. Does your child rest during the day? ☐ No ☐ Yes
15. Is your child toilet trained? ☐ No ☐ Yes
16. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? ☐ No ☐ Yes Explain
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? ☐ No ☐ Yes Explain
18. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? ☐ No ☐ Yes Explain

Illness History *(please check all that apply)*

☐ Vision problems	☐ Nosebleeds	☐ Seizures
☐ Hearing problems	☐ Skin rashes	☐ Mouth sores
☐ Constipation	☐ Sore throats	☐ Fainting
☐ Diarrhea	☐ Ear infections	☐ Persistent cough
☐ Asthma/breathing problems	☐ Urinary tract infections	☐ Other

Please attach care instructions from your physician for any of these illnesses.

Disease History *(please check all that apply and add the date)*

☐ Chicken Pox (Varicella)		☐ Bronchiolitis		☐ Botulism	
☐ Measles Rubeola		☐ Pneumonia		☐ Haemophilus Influenza	
☐ Rubella (German Measles)		☐ Pertussis (Whooping cough)		☐ Meningococcal Infection	
☐ Mumps		☐ Tetanus		☐ Rabies	
☐ Scarlet Fever		☐ Diphtheria		☐ Bacterial Meningitis	

Allergies *(please list)*

Medication Allergies	Reaction	Food Allergies	Reaction
Bee Stings Allergies	Reaction	**Respiratory** Allergies	Reaction
Other Allergies	Reaction	**Are any of these allergies life-threatening?** ☐ **Yes** ☐ **No**	

Please attach care instructions from your physician for any life-threatening allergies.

Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

☐ Vision		☐ Developmental		☐ Tuberculosis (PPD)	
☐ Hearing		☐ Aptitude		☐ Sickle Cell Anemia	
☐ Speech		☐ Educational		☐ Other	

To the best of my knowledge the information contained above is accurate.

Parent initial _____ Staff initial _____ Date _____

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Enrollment Agreement Beyond the Spectrum LLC

Medical Information (continued)

Child's name	Birth date

Child's Medical Care Provider

Primary physician's name	Primary physician's practice name		Phone	
Physician's practice address		**City**	**State**	**Zip**
Preferred hospital/clinic for emergency care		**City**		**State**
Dentist's name	**Dentist's practice name**		**Phone**	
Dentist's practice address		**City**	**State**	**Zip**

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number

Child's Immunization History *(please attach a copy of your child's immunization records)*

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state. **[Check with your state requirements. You may do this at http://www.immunize.org/states/ Bold any immunization below that is a requirement.]**

Anthrax	Influenza	**Pneumococcal disease**	Smallpox
Diphtheria	Lyme Disease	**Polio**	**Tetanus**
Haemophilus Influenzae type b (Hib)	**Measles**	Rabies	Tuberculosis
Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
Hepatitis B	**Mumps**	**Rubella**	**Varicella (Chickenpox)**
Human Papillomavirus (HPV)	**Pertussis (Whooping Cough)**	Shingles (Herpes Zoster)	Yellow Fever

Additional Medical Policies

	Initial
1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.	
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.	
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.	
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*.	

Emergency Medical Authorization & Consent

	Initial
In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician.	
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.	
In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.	
In case of a medical emergency, I will be responsible for the emergency medical expenses.	
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.	

	Initial
I give my permission to this center to apply □ sunscreen and □ insect repellant to my child. *Please check which products you will permit.*	
I understand that I must supply my own sunscreen and/or insect repellant with a valid expiration date, and it will be labeled with my child's name.	
I □ have □ do not have special instructions for the application process. _____	

Parent initial _____ Staff initial _____ Date _____

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Enrollment Agreement

Beyond the Spectrum LLC

Rate Agreement and Contract

Child's name | Birth date

Hours of Operation

Regular operating hours are **7:00am- 12:00 am** except closings for various holidays, and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures.

The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on Phone, Text, News, and Facebook . If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release*, and it will be your responsibility to arrange for your child's early pick up.

Scheduled Attendance

The days and hours that I wish to contract for child care are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

I would prefer to make tuition payments on a ☐ weekly ☐ bi-weekly ☐ monthly basis.

Fee Policy (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)

- Starting on _____ a fee of $_____ is due ☐ weekly. ☐ bi-weekly. ☐ monthly. — Initial
- Tuition is due and payable by Every Friday before 10am ☐ Every Friday . ☐ the 1st and 15th of the month or next business day. ☐ first business day of the month. — Initial
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather or pandemic), or absence other than hospitalization, or absence at the request of a doctor (a written doctor's note is required to receive credit). — Initial
- I agree to pay the full tuition in advance of services rendered. — Initial
- I agree to pay the full tuition fee even if my child is absent for one or more days. — Initial
- A late fee of $5 per day is due if tuition is not received on time. — Initial
- A non-refundable registration fee of $65 is due yearly. — Initial
- A late pick up fee of $5 per minute per child (not to exceed $40 per child) is due if my child is not picked up before closing. — Initial
- Accounts two weeks in arrears may result in immediate termination of service. — Initial
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip may be required. — Initial
- All returned checks or ACH transactions (automatic debits) will be charged a fee of $35.00. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status. — Initial
- A 2 -week written notice is required for any child being withdrawn from the program. Failure to provide notice in writing will result in forfeiture of deposit. — Initial
- A receipt for income tax purposes ☐ will ☐ will not be provided. — Initial

Other Agreements

Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected to or sanctioned by this center. This center shall remain harmless from any such arrangement. — Initial

Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program. — Initial

Parent initial _____ Staff initial _____ Date _____

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Other Agreements *(continued)*

Child's name	Birth date

Walking Excursions

	Initial
I give my permission for my child to participate in supervised walking excursions near and around the center.	

Handbook Acknowledgement

	Initial
I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.	
I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.	
Information contained in the Family Handbook may be subject to change.	

Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement*.

Primary Parent/Guardian/Sponsor Signature	Date	Center Staff Signature	Date

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School Age Child Care Supplemental Enrollment Form

Beyond the Spectrum LLC

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

Enrollment Information

Child's Information

Child's first name	Child's middle name	Child's last name	Child's nickname
Age / Sex	Child's primary language	Parent/guardian/sponsor primary language	
Child's home address	City	State	Zip
Does your child attend school? ☐ Yes ☐ No	School name	Grade	School phone
School address	Drop off time		Pick up time
Child will be attending:	☐ Morning Care	☐ Afternoon Care	
My Child is allowed to walk	☐ To School from Child Care	☐ From School to Child Care	

*Note: Beyond the Spectrum LLC is not liable for the child until he/she arrives at the program or after the child has left the program to walk to/from school.

After School Activities Information

Complete the information below to provide us with details about after school activities your child is participating in. Please complete a separate Transportation and School Activity form for each activity.

Transportation and After School Activity

My child is transported to school via:	My child is transported from school via:			Bus #:
Parents are responsible for informing child care center in writing if your child(ren) will be participating in an after school activity:				
Child participates in the following after school activities (list all):				
Type of Activity:				
Day of the week child is attending activities (circle all that apply): M Tu W Th F				
Time period of activity: Day: Start Time: End Time:	Day: Start Time: End Time:	Day: Start Time: End Time:	Day: Start Time: End Time:	Day: Start Time: End Time:
Name of authorized person to pick up / drop off your child for the extracurricular activity:				

Transportation and After School Activity

My child is transported to school via:	My child is transported from school via:			Bus #:
Parents are responsible for informing child care center in writing if your child(ren) will be participating in an after school activity:				
Child participates in the following after school activities (list all):				
Type of Activity:				
Day of the week child is attending activities (circle all that apply): M Tu W Th F				
Time period of activity: Day: Start Time: End Time:	Day: Start Time: End Time:	Day: Start Time: End Time:	Day: Start Time: End Time:	Day: Start Time: End Time:
Name of authorized person to pick up / drop off your child for the extracurricular activity:				

Your child's safety is our number one priority. Beyond the Spectrum LLC will not release children from the program without the above information **in writing**.

_____ Primary Parent/Guardian/Sponsor Signature

_____ Date

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Student Data Form

(This form should be updated each year)

Date: _____

Student Name: _____

Birthday: _____ (please circle) **boy** or **girl**

Parent/Guardian: _____

Address: _____

_____

Phone # _____ cell # _____

Work # _____ email _____

If student does not live at the above address, please list student's current address.

Student lives with: _____

Address: _____

_____

Phone # _____ cell # _____

Work # _____ email _____

Does student have any medical issues that preschool staff should be aware of? **YES** or **NO**

If YES, please describe: _____

_____

Does student have a current Individualized Education Plan (IEP)? **YES** or **NO**

Note to preschool staff - A copy of IEP or IEP-At-A-Glance should be filed with this form in Student Information Notebook (if applicable). All student information is CONFIDENTIAL.

Consent for Emergency Medical Care

Child's Name _____

Birthday _____

I give my permission for school personnel to assist my child in administering the following medications for minor injuries or illness. The school will furnish the following medications **as needed and when available**: antibiotic ointment (minor cuts & abrasions), anti-itch cream (soothe rash/hives), Vaseline (chapped lips/skin), lotion (dry skin), aloe gel (soothe sunburn), insect sting swabs (soothe bee stings, Does NOT treat allergic reaction), and saline (minor eye irritations).

I give permission for my child to receive and participate in health and related services offered by the school system. Such services may include services of a school nurse, school counselor, health educator, dental and nutrition programs, vision, speech/hearing screenings, height/weight, blood pressure, scoliosis and communicable disease screenings. If screenings are not within normal limits, parents/guardians will be notified.

In an emergency situation, if parent(s) cannot be reached, the student will be transported by ambulance to the hospital emergency room. Efforts to notify parent(s) will continue until they are reached.

List any exceptions to the above _____
Allergies/allergic reactions _____
Conditions/Concerns _____

Name of Doctor's Office _____
Doctor's Name _____
Doctor's address _____
_____
Doctor's phone # _____

Parent/Guardian signature _____
Date _____

Dear Families,

Please complete the following questions in order to be sure that your child is safe while attending our preschool program. We need to know if your child has any food allergies or bee sting allergies. In addition, we need to know if your child has a rescue asthma inhaler.

Please complete this questionnaire and return to school.

Student's Name _____

Teacher _____

Is your child allergic to peanuts? Yes _____ No _____
Is your child allergic to tree nuts? Yes _____ No _____

Does your child have any food allergies? Yes _____ No _____
If you answered YES, please list all food allergies:
_____

Is your child allergic to bee stings? Yes _____ No _____
Does your child have an EpiPen? Yes _____ No _____

Does your child have asthma? Yes _____ No _____
Does your child have an inhaler? Yes _____ No _____

Acknowledgement of receipt of Parent Handbook

Dear Families,

Please read the attached Parent Handbook. If you have any questions about program policies, please ask your child's teacher.

Please sign and return this form in order to verify that you have received a copy of The Parent Handbook.

Student Name _____

_____

Parent/Guardian Signature

_____

Date

Acknowledgement of Receipt
Summary of Child Care Approval Requirements

Dear Families,

All preschool programs must meet the requirements as defined by the TN State Board of Education School Administered Child Care Rules, chapter 0520-12-01. I have attached a Summary of Child Care Approval Requirements for you.

In addition, I have put together a notebook of Parent Resources for your reference in the classroom. Resources include The Standards for Infant/Toddler, Preschool and School-Age Extended Care Programs, as well as a copy of our Parent Handbook, TN Early Developmental Standards and Notice of Procedural Safeguards(IDEA). You are invited to review these resources.

Please sign and return this form in order to verify that you have received a copy of the Summary of Child Care Approval Requirements.

Student Name _____

_____
Parent/Guardian Signature

_____
Date

Personal Safety Curriculum

Dear Families,

During this school year, a personal safety curriculum will be presented to our preschool students. The purpose of this curriculum is to teach children how to be safe. State law also mandates that every licensed preschool program provide a child abuse prevention program each school year for enrolled children. A component of the child abuse prevention program provides information for parents & guardians.

Curriculum materials have been developed for preschool age children. Information will be presented as part of a two week unit plan. The topics will include:

- Learn about Car Safety
- Learn about Fire Safety
- Getting Found
- Getting & Giving Safe Touches

You are invited to review the instructional materials and curriculum guide in our classroom.

Please sign and return this form in order to verify that you have been informed of the personal safety curriculum.

Student Name _____

_____
Parent/Guardian Signature

_____
Date

Permission to Photograph

Children may be photographed while engaging in classroom or school sponsored activities. Children may be included in videos while participating in activities at school or at school sponsored functions. Photographs and/or videos may be used in the following ways:

- in school yearbook
- on school and/or district website
- in classroom or school newsletters
- in classroom or hallway displays
- shared with local media (may include newspaper or television)

Please sign and return this form. Please indicate if you give permission for your child to be included in photographs or videos.

_____ I give permission for my child to be included in photographs or videos.

_____ Please Do Not photograph or video my child. School does not have permission to include my child in photographs or videos. Please indicate any exceptions to this statement: _____

_____

Student Name _____

_____

Parent/Guardian Signature

_____

Date

Classroom Use of Movie, Video and/or Computer Games

Dear Families,

Preschool children will have opportunities to learn and to practice skills with computer technology (which may include iPad/tablet, computer, Smart Board). All programs which students may access are appropriate for preschool age children. In addition, all computer systems are equipped with filtering software in order to inhibit access to inappropriate websites. School staff will closely supervise students' choices during computer based activities.

Throughout the year, children will have opportunities to see educational and/or entertainment movies. All movies will be rated G (For All Audiences) and/or approved for preschool educational purpose. During movie/TV or computer activities, preschool children will have access to optional instructional materials.

Please sign below and return in order to verify you have been informed regarding classroom use of movies, video and/or computer games.

Student Name _____

_____
Parent/Guardian Signature

_____
Date

Transportation Plan

Child's name: _____
Birthday: _____

Home address: _____
_____
_____
_____

Home phone # _____
Cell phone # _____

(1)Parent/Guardian Name _____
relationship _____
Place of Employment _____
Work phone # _____
Cell phone # _____

(2)Parent/Guardian Name _____
relationship _____
Place of Employment _____
Work phone # _____
Cell phone # _____

Please indicate if your child will ride the bus or be a car rider for arrival and at dismissal.
Arrival _____
Dismissal _____

Please note:
It is understood that daily changes may be needed due to appointments or family commitments. Please send a written note to the teacher for daily changes to Transportation Plan.

Emergency Contacts

Please list relatives or neighbors who could assume temporary care of your child if you cannot be reached. These individuals may pick your child up from school.

Name _____
(how related) _____
Address _____
_____
_____
Phone #1 _____
Phone #2 _____

Name _____
(how related) _____
Address _____
_____
_____
Phone #1 _____
Phone #2 _____

Name _____
(how related) _____
Address _____
_____
_____
Phone #1 _____
Phone #2 _____

Parent/Guardian Signature _____
Date _____

Beyond the Spectrum Income Verification	Beyond the Spectrum **INCOME ELIGIBILITY APPLICATION FOR BEYOND THE SPECTRUM**	Form HS-IC 0831 Revised September 2025

PART 1 – NAME _____
Last First MI

PART 2A - IF YOU ARE CURRENTLY RECEIVING FAMILIES FIRST (FF) CASH ASSISTANCE , OR YOU (OR A MEMBER OF YOUR HOUSEHOLD) ARE RECEIVING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS, COMPLETE THIS PART AND SIGN THE STATEMENT IN PART 4 - DO NOT COMPLETE PART 2C.) ACCENT Case Number for SNAP or FF Cash Assistance: _____

PART 2B - IF YOU COMPLETED 2A ABOVE, IDENTIFY BELOW THE CHILDREN 12 YEARS OF AGE AND UNDER WHO ARE LIVING IN YOUR HOME (ATTACH ADDITIONAL SHEETS AS NECESSARY):

1. _____ Name Birth Date
2. _____ Name Birth Date
3. _____ Name Birth Date

PART 2C – ALL OTHER HOUSEHOLDS (If no information is entered in Part 2A above, complete this part, and sign the statement in Part 4. Attach additional sheets as necessary)

Names of All Household Members	Earnings from Work (Before Deductions)	Child Support, Alimony or Other Income	Payments Received from Pensions, Retirement, & Social Security
1.	$_____ per year	$_____ per year	$_____ per year
2.	$_____ per year	$_____ per year	$_____ per year
3.	$_____ per year	$_____ per year	$_____ per year
4.	$_____ per year	$_____ per year	$_____ per year

Total Number of Household Members: ___ **Total Yearly Income for Household from All Sources: $** _____ Yearly income is calculated as follows: Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers during the conversion.

PART 2D – FOSTER CHILD (Complete this part and sign the statement in Part 4.) If any household member is a foster child, check here: ____. A foster child is the legal responsibility of a state children services agency or court, and is categorically eligible for free meals.

PART 3 – Medicaid and State Children's Health Insurance Programs – Please check if you do **not** want the information in this application to be shared with the Medicaid and State Children's Health Insurance Programs: ___ DO NOT WANT APPLICATION INFORMATION TO BE SHARED WITH THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

PART 4 – SIGNATURE (An adult household member must sign the application.) PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct. I understand that this information is being given for the receipt of Federal Funds; that institution officials may verify the information on the statement; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of Provider:	Social Security Number (only last four digits):	Home Telephone:

PART 5 – ETHNIC/RACIAL IDENTITY (**You are not required to answer this question.**): **For Ethnicity**, please check one of the following: ___ Hispanic or Latino ___ Not Hispanic or Latino. **For Race**, please check one or more of the following: ___ American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or Other Pacific Islander ___ White. Please see the definitions of Ethnicity and Race on the back of this application.

FOR SPONSORING AGENCY USE ONLY: Classification (Circle): Tier 1 **or** Tier 2
Basis for Classification (Circle) Categorically Eligible **or** Income Eligible

Determining Official Signature: _____ Date: _____

INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

PART 1 - PROVIDER INFORMATION: All HOUSEHOLDS COMPLETE THIS PART.
(1) Print your full name and address.

PART 2A - HOUSEHOLDS RECEIVING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM OR FAMILIES FIRST CASH ASSISTANCE: COMPLETE THIS PART AND PART 4.
(1) List your current Supplemental Nutrition Assistance Program or Families First Cash Assistance Case Number. (2) If any portion of this Part is completed, do not complete Part 2C.

PART 2B - IDENTIFICATION OF CHILDREN 12 YEARS OF AGE AND UNDER WHO ARE LIVING IN YOUR HOME: COMPLETE THIS PART IF ANY PORTION OF PART 2A IS COMPLETED.
(1) List the names and birth dates of all children who reside in your home and have not reached their thirteenth birthday.

PART 2C - ALL OTHER HOUSEHOLDS: COMPLETE THIS PART AND PART 4.
(1) Write the names of everyone in your household. Households with foster and non-foster children may choose to include the foster child(ren) as household members, as well as any personal income earned by the foster child(ren), on the same household application that includes the non- foster child(ren).

(2) Write the amount of the income received on a yearly basis for each household member. The income may be for the current month, the amount projected for the first month the application is made for, or for the month prior to application. This income is the amount before taxes or any deductions are made. Also, indicate the source of the income. Refer to examples below for income to report.

INCOME TO REPORT

Earnings from Work Retirement/Social Security Other Income Sources Child Support/Alimony Wages/salaries/tips Pensions Disability benefits
Alimony/child support Strike benefits Supplemental Security Income Cash withdrawn from savings benefits/payments Unemployment benefits Retirement income Interest/dividends
Worker's Compensation Veteran's payments Income from estates/trusts/investments Net income from Social Security
Income Regular contributions from persons
self-employment not living in the household
Net royalties/annuities/net rental income

PART 2D - HOUSEHOLDS WITH A FOSTER CHILD: COMPLETE THIS PART AND PART 4 – **A foster child is the legal responsibility of a state children services agency or court, and is categorically eligible for free meals.** A foster parent or other official representing the child must sign the statement in PART 4.

PART 3 – MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS – Federal law allows the sharing of the information on this application with Medicaid and State Children's Health Insurance Programs. At this time, no procedures are in place to share this information. Since the procedures to share this information with the Medicaid and State Children's Health Insurance Programs may be established in the future, please indicate if you do not want this information to be shared. The Medicaid and State Children's Health Insurance Programs can only use the information to identify children who may be eligible for free or low cost health insurance and to enroll them in either Medicaid or the State Children's Health Insurance Program. They are not allowed to use the information for any other purpose. If this information is not shared, it will not affect the eligibility of your child(ren) for Tier 1 meals. If you do not want to share the information with the Medicaid and State Children's Health Insurance Programs, please indicate this decision by entering a check.

PART 4 – SIGNATURE AND SOCIAL SECURITY NUMBER: All households complete this part.
(1) All income eligibility statements must have the signature of an adult household member.
(2) The adult household member who signs the statement must include the last four digits of his/her Social Security Number. If he/she does not have a Social Security Number, write "none". If you listed an ACCENT case number for Supplemental Nutrition Assistance Program or Families First cash assistance, or a case number for Families First Child Care Assistance, the last four digits of the Social Security Number are not needed. (3) The income eligibility application is valid for one calendar year from the date of the signature of the Determining Official. You will be contacted by the staff of the child care institution serving your child(ren) to update the information contained in this application before the close of the eligibility period. The staff of the child care institution is required to verify and certify the eligibility of your household every 12 months. Section 9 of the National School Lunch Act requires that, unless the participant's Supplemental Nutrition Assistance Program or Families First case number is provided, you must include the last four digits of the Social Security Number of the household member signing the statement or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last four digits of a Social Security Number is not mandatory, but if this Social Security information is not provided or an indication is not made that the adult household member signing the statement does not have a Social Security Number, the statement cannot be approved.

PART 5 - RACIAL/ETHNIC IDENTITY: You are **not required** to answer this question to receive meal benefits. However, this information will help ensure that everyone is treated fairly. **Definition of Ethnicity:** *Hispanic or Latino* means *a* person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. **Definition of Race:** *American Indian or Alaskan Native* means a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. *Asian* means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *Black or African American means a* person having origins in any of the black racial groups of Africa. *Native Hawaiian or Other Pacific Islander means a* person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. *White* means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the CACFP on the grounds of race, color, sex, age, disability, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
CITIZENS PLAZA BUILDING
400 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-1403

TELEPHONE: 615-313-4700 FAX: 615-532-9956
TTY: 1-800-270-1349
www.tn.gov/humanserv/

BILL LEE
GOVERNOR

DANIELLE W. BARNES
COMMISSIONER

Influenza Information Notification

PUBLIC CHAPTER 687 requires the Department of Human Services and the Department of Health to work together to educate parents of children in child care agencies regarding the importance of immunizing their children against influenza. The Department of Human Services works with child care agencies to ensure that this information is distributed annually to parents in August and September.

I/We acknowledge that we have received information on the importance of immunizing children against influenza.

_____
Signature of Parent or Legal Guardian Date

_____
Signature of Parent or Legal Guardian Date

_____
Signature of Child Care Agency Representative Date

APPENDIX 6-D

CHILD'S HEALTH HISTORY CHECKLIST

Child's Name _____ Birth date _____ Parent or Guardian's _____

The answer to these questions will help us to know if your child has any medical problems. We need this information in case he/she should become ill and we would be unable to reach you right away. Please circle the right answer. We will go over the checklist with you when you have finished.

Pregnancy and Birth

Yes No 1) Were there any problems with pregnancy of your child's birth?
Yes No 2) Was his/her birth weight under 5 1/2 pounds?
Yes No 3) Did the baby have any problems in the hospital?

Medical Problems

Yes No 4) Has your child ever been in the hospital overnight?
Yes No 5) Is your child taking any medicine?
Yes No 6) Any allergies or reactions to medicine, DTP or other shots, or insects?
Yes No 7) Has your child has asthma or wheezing?
Yes No 8) Does your child have speech or hearing problems?
Yes No 9) Has your child had more than two ear infections in a year?
Yes No 10) Has your child had tonsillitis?
Yes No 11) Does your child have trouble with his/her eyes or seeing?
Yes No 12) Has your child had a bladder or kidney infection?
Yes No 13) Does he/she have burning when urinating?
Yes No 14) Does he/she have seizures, fits or shaking spells?
Yes No 15) Have you ever been told your child has a heart murmur?
Yes No 16) Is your child able to play as hard as other children?
Yes No 17) Has your child ever had a bumpy, swollen reaction to the TB skin test?
Yes No 18) Has your child ever been with anyone having TB?
Yes No 19) Has your child ever had worms?
Yes No 20) Does your child scratch his/her genital area?
Is his/her bottom or genitals red or sore?
Yes No 21) Is your child a hemophiliac (free bleeder)?
Yes No 22) Is your child on a heart monitor?
Yes No 23) Does your child have tubes in his/her ears?