Emergency Contact/Parental Consent Form

55 PA CODE CHAPTERS 3270.124(a)(b); 3270.181 & 182; 3280.124(a)(b); 3280.181 & 182; 3290.181 & 182

Child's Name:	Birth Date:	Enrollment Date:

Child's Address:

_____ Street/Apt #/PO Box _____ City _____ State _____ Zip Code

Mother/Legal Guardian Contact Information:	Father/Legal Guardian Contact Information:
Name: _____	Name: _____
Home #: ( ) _____	Home #: ( ) _____
Mobile #: ( ) _____	Mobile #: ( ) _____
Work #: ( ) _____	Work #: ( ) _____
Email Address: _____	Email Address: _____
Home Address: ☐ *same as child* _____ Home Address	Home Address: ☐ *same as child* _____ Home Address
☐ Employment OR ☐ School: Business or School Name: _____ *Address:*	☐ Employment OR ☐ School: Business or School Name: _____ *Address:*

Emergency Contact Person(s) (in addition to the parents) Name, Relationship, and Phone #:

1. _____
2. _____
3. _____

I give permission for my child to be released to any of the following person (s) (18 years of age of older) when I am unable to pick my child up from the classroom or bus stop (in addition to the parents). Name, Address, Relationship & Phone #

1. _____
2. _____
3. _____
4. _____

Physician Name: _____

Physician Address: _____

Physician Phone #: _____

Insurance Information: _____

ID#: _____ Group #: _____

Allergies: _____

Special Disabilities / Medical Conditions / Special Needs / Dietary Restrictions:

Parent/Legal Guardian Permission:

Obtaining Emergency Medical Care _____ *Initials*

Transportation by Facility _____ *Initials*

Admin. Of Minor First Aid Procedures _____ *Initials*

Walks and Trips _____ *Initials*

Wading/Sprinklers _____ *initials*

X _____

Signature of Parent or Guardian

Date: _____

Agreement

55 PA CODE CHAPTERS 3270.123 & 181 (c); 3280.123 & 181 (c); 3290.123 & 181 (c)

Name of Child: **Facility Location: New Castle or Pulaski**

Private Pay Amount: $_____ per day; due Monday prior to attendance
Agency Amount: $_____ per week; due Monday prior to attendance

Services to be provided as part of the daycare fee (example: transportation, care, meals, etc.)

- We shall provide a safe and pleasant environment that will enhance your child's growth and development.
- We provide good and nutritious meals aligned to the CACFP program standards (Breakfast, AM Snack, Lunch, PM Snack based on arrival and departure time).
- We enhance your child's social and emotional skill with peers and staff members.
- We provide opportunities for your child to enhance gross and fine motor skills both indoors and outdoors.
- We provide opportunities for your child to engage in problem solving.
- We enhance your child's language abilities through speaking, listening and checking for understanding through discussions and story books.
- We teach proper writing skills to each child.
- We observe and assess each child's development by using Ages and Stages and Vine assessments.
- We provide safe transfer of care for our school age children per our policy located in our handbook

Childcare

___Monday __Tuesday ___Wednesday ___Thursday ___Friday

3 Half Day or 3 Full days – Required.

Extra services to be provided at an additional fee if applicable:

- NSF checks and declined credit cards will accrue a $40.00 fee.
- Registration fee: $80 per child
- Re-registration fee: $50 per child
- Annual supply fee: $45 per family-around September
- $3.00 per day diapering fee for children 3 and older who are still in diapers/pull ups.
- A late payment fee of $35 will occur on Tuesday for nonpayment of previous week of service.
- Overtime fee will be charged on a prorated rate of $10.25 an hour for late pickups that are over 10 hours of service.
- Late pickup fee of $50 plus $10.25 per hour, for after business hour pickups.
- Vacation, absent week, non-scheduled week will occur a $85 Per Week, per child
- No schedule fee: $3

Childs Arrival Time: _____ AM/PM (Approx.) **Childs Departure Time: _____ AM/PM (Approx.)**

Person(s) designated by parent to whom child may be released: SEE EMERGENCY CONTACT SHEET

I, the parent/guardian:

□ **Received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)**

□ **Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.121, 3280.121, 3290.121)**

Signature– Director	Date	Signature– Parent/Guardian	Date

Date of Child's Admission:_____ **Date of Child's Withdrawal:_____**

Getting to Know Your Child

Child's Name_____ Nickname (if applicable) _____

Has your child been in an early learning program or childcare center before? **Yes or No**

- If **yes**, would you share some information with us? (Where? When? For how long? Reason for leaving?)

_____

Does your child have any unusual eating problems or food dislikes? **Yes or No**

- If **yes,** please explain. _____

Does your child have any allergies? **Yes or No**

- If **yes**, what are they? How severe? What steps should be taking if your child has a reaction?

_____

Are there any important routines at drop off/pick up/naptime/etc., that would be helpful for us to know about? _____

Does your child usually nap? _____How long? _____ What Times? _____

Is your child in diapers? _____ Pull-ups? _____ Fully potty trained? _____

Does your child have any fears or nervous habits? **Yes or No**

- If **yes**, what are they and what can we do to help?

_____

What is your attitude towards discipline? _____

Any further information that might be helpful in understanding your child (visual or physical handicaps, for example):_____

_____

Names and ages of your child's brother(s) and/or sister(s): _____

What are your expectations from our program for your child? _____

_____

Where did you hear about us? (Please Circle) Internet Search, Our Website, ELRC, Facebook, Parent Referral, Center Referral, Other (please explain): _____

For office use Only

Start Date: _____

Reviewed By:

Director: _____ Date: _____

Group Supervisor: _____ Date: _____

Rev 7/1/22

Permission Form

Child's Name: _____ Date: _____

I give permission for my **child** to be transported to and from Pre-K Kids Learning Center. _____ **Initials**

This permission form Authorizes Pre-K Kids Learning Center to transport my child in any emergency.

If the child named above has special needs or problems that require special care while being transported, such as seizures or motion sickness, please write instructions on back of this form.

I give permission for Pre-K Kids Learning Center to photograph my child for the following purposes: _____ **Initials**

Please check one for each line

Type of Use	Yes	No
Display photos in the teacher made books that may go home with current clients. (Only first names may be displayed with their pictures in teacher-made books)		
Display still photos on Pre-K Kids Learning Center website		
Send photos through our parent communication system (ex: ProCare) possibly containing your child to current clients		
Post photos on Pre-K Kids Facebook page		

I give Pre-K Kids Learning Center permission to use the following on my child, as needed. _____ **Initials**

I understand that only products I have supplied will be used.

Circle One

Sunscreen	Yes	No
Diaper Cream	Yes	No

This only applies for the New Castle Office

I give permission for my child to walk to Shenango Park with Pre-K Kids Learning Center Staff. _____ **Initials**
I/We understand all reasonable safety precautions will always be taken by Pre-K Kids Learning Center and its agents during the events and activities.

I understand that it is my responsibility to update this form if I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____

(Parent or Guardian Signature) (Date)

Rev 4/29/25

Automated Payments Processing
Safe – Convenient - Easy

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 either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize **Pre-K Kids Learning Center** to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____ CVV Number _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

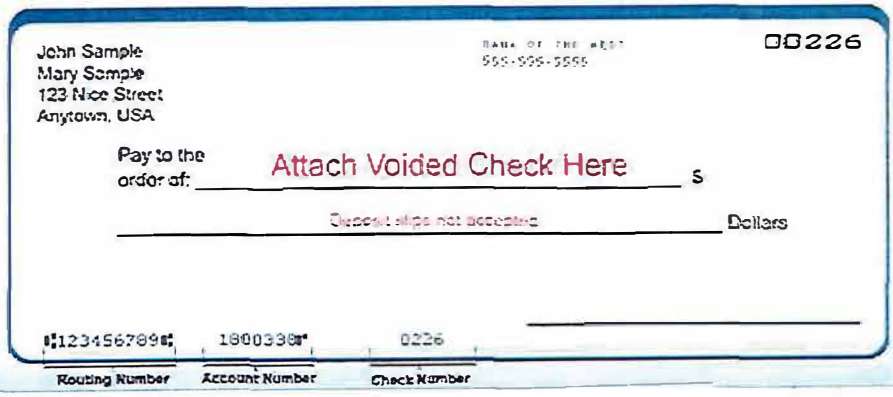
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ Checking ☐ Savings ☐

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



A service of procare SOFTWARE

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST) (FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH: HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:	
FACILITY PHONE: COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE *THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF,* EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Pre-K Kids Learning Center Inc.
2740 Ellwood Rd. New Castle, PA 16101
(724) 652-0922 - www.prekkidslearningcenter.com

CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care home or center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us at:

Pre-K Kids Learning Center.

Step 1:

List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes*, mark the correct boxes next to the child's name and go to Step 4.

Step 2:

You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

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How do you report income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write *0* in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children don't have to be U.S. citizens to qualify for meal benefits.
You are in the military	Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

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CACFP Meal Benefit Income Eligibility Form
Sharing Information with Medicaid and SCHIP

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to*. Medicaid and SCHIP *only* use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

☐ **No! I do not** want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Today's Date: _____

Print Your Name:

_____

Address: _____

Signature of Parent or Guardian:

_____

If you have questions or need help, please contact **Eduviges Miller** at **724-652-0922** or email **e.miller@prekkidslearningcenter.com**.

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7/1/2025

Dear Parent or Guardian:

Pre-K Kids Learning Center offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). **PreK Kids Learning Center** receives support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2025 - June 30, 2026		
Household size	Yearly Income	Monthly Income
1	$28,953	$2,413
2	$39,128	$3,261
3	$49,303	$4,109
4	$59,478	$4,957
5	$69,653	$5,805

Please fill out a *CACFP Meal Benefit Income Eligibility* form. It will help us find out how much support **Pre-K Kids Learning Center** receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please send the completed form to:

Pre-K Kids Learning Center 2740 Ellwood Rd. New Castle, PA 16101.

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability. If you have questions or need help, please contact **Eduviges Miller at 724-652-0922 or e.miller@prekkidslearningceter.com.**

Sincerely,

Eduviges Miller

Eduviges Miller
Director

This institution is an equal opportunity provider.

Child and Adult Care Food Program
Child Enrollment Form

Sponsor/Center Name: Pre-K-Kids Learning Center
Agreement #: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	☐ MONDAY									
NAME	☐ TUESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
BIRTH DATE	☐ WEDNESDAY	Other:								☐ A.M. SNACK
AGE	☐ THURSDAY									☐ LUNCH
	☐ FRIDAY									☐ P.M. SNACK
		Enrollment Date:			Withdrawal Date:					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
SECOND CHILD	☐ *Same as Above*									☐ *Same Meals as Above*
NAME	☐ MONDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
BIRTH DATE	☐ TUESDAY	Other:								☐ A.M. SNACK
AGE	☐ WEDNESDAY									☐ LUNCH
	☐ THURSDAY									☐ P.M. SNACK
	☐ FRIDAY	Enrollment Date:			Withdrawal Date:					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
THIRD CHILD	☐ *Same as Above*									☐ *Same Meals as Above*
NAME	☐ MONDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
BIRTH DATE	☐ TUESDAY	Other:								☐ A.M. SNACK
AGE	☐ WEDNESDAY									☐ LUNCH
	☐ THURSDAY									☐ P.M. SNACK
	☐ FRIDAY	Enrollment Date:			Withdrawal Date:					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FOURTH CHILD	☐ *Same as Above*									*Same Meals as Above*
NAME	☐ MONDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
BIRTH DATE	☐ TUESDAY	Other:								☐ A.M. SNACK
AGE	☐ WEDNESDAY									☐ LUNCH
	☐ THURSDAY									☐ P.M. SNACK
	☐ FRIDAY	Enrollment Date:			Withdrawal Date:					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIFTH CHILD	☐ *Same as Above*									☐ *Same Meals as Above*
NAME	☐ MONDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST
BIRTH DATE	☐ TUESDAY	Other:								☐ A.M. SNACK
AGE	☐ WEDNESDAY									☐ LUNCH
	☐ THURSDAY									☐ P.M. SNACK
	☐ FRIDAY	Enrollment Date:			Withdrawal Date:					

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: Effective Date of This Enrollment Form: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This portion of the form can be used to capture multi-year annual updates.

****

****

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian_____ Date _____

Signature Center Administrator/Home Provider_____ Date _____

****

****

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian_____ Date _____

Signature Center Administrator/Home Provider_____ Date _____

****

****

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian_____ Date _____

Signature Center Administrator/Home Provider_____ Date _____

****

****

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian_____ Date _____

Signature Center Administrator/Home Provider_____ Date _____

****

****

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. *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.

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (If more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Address

City

State

Zip

Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - *Disability Payments* - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member regularly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• *Unemployment benefits* • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local *government* • Alimony payments • Child support payments • Veterans benefits • *Strike benefits*	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. *Responding to this section is optional* and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

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, the funds your child care center/provider receives may be impacted. You must *include the last four digits of* the social security number of the adult household member who signs the application. The last four digits of 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) case number or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for *program reviews, and law enforcement officials* to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT 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

How often?

Weekly	Bi-Weekly	Monthly	2x Month
○	○	○	○

Household size

Categorial Eligibility ☐

Eligibility

Free	Reduced	Denied
○	○	○

Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date