



Before & After School Registration Form

\$20 registration fee due.

Parent/Guardian Information

Date: _____

Mother/Guardian First Name: _____ M.I. ____ Last Name: _____

Address: _____

Occupation: _____ Home Phone: () _____

Employed By: _____ Office Phone: () _____

Work Address: _____ Work Hours: _____

Cell Phone: () _____ Cell Phone Carrier: _____ (for texting purposes)

Email: _____ Best way to reach: _____

Marital Status: Married Single Divorced Separated Widowed Other _____

Father/Guardian First Name: _____ M.I. ____ Last Name: _____

Address: _____

Occupation: _____ Home Phone: () _____

Employed By: _____ Office Phone: () _____

Work Address: _____ Work Hours: _____

Cell Phone: () _____ Cell Phone Carrier: _____ (for texting purposes)

Email: _____ Best way to reach: _____

Marital Status: Married Single Divorced Separated Widowed Other _____

Child Information

First Name: _____ M.I. _____ Last Name: _____

Age: _____ DOB: _____ Gender: Male Female

List any existing medical conditions, medication and/or special attention your child may require.

Allergies: _____



Rate Agreement and Contract

Child's name	Age	Grade
--------------	-----	-------

Hours of Operation

Regular operating hours are **Monday through Friday from 6:00 a.m. to 6:00 p.m.** except closings for various holidays and inclement weather as described in the Before and After School 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 through text message to parents using available contact information. If it becomes necessary to close early, we will contact you or someone listed in the *Child Emergency Information & Consent Form*, 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 before and after school care are as follows:

Day of Week	Before School Drop-Off Time	Bus Pick-Up Time	After-School Bus Drop-Off Time	Parent Pick-Up Time	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

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

- Starting on _____, a weekly fee of _____ is due. **Initial:** _____
- Tuition is due and payable in advance (by midnight on Friday) for services to be rendered. _____
- Tuition is \$45.00 a week. Tuition will be adjusted for weeks with three or fewer days based on the school calendar. _____
- A late fee of 5% is due if tuition is not received by midnight on Wednesday during the week that services are provided and will be applied to the entire balance due as of Thursday at 12:01 a.m. This fee will be added to your bill the following week. _____
- Tuition is not subject to any credits for holidays or emergency closures (i.e. weather). _____
- I agree to pay the full tuition fee even if my child is absent for one or more days. _____
- A non-refundable registration fee of \$20.00 is due upon enrollment. _____
- A late pick-up fee of \$1.00 per minute per child is due if my child is not picked up before closing. _____
- If tuition is not paid by the end of the week of service, I understand that my child may not be permitted to return the following week and a face-to-face meeting between both parents and the board may be required. _____
- My child may have the opportunity to participate in special programs that may have an additional fee. _____
- All NSF checks or returned online transactions will be charged a fee of \$25.00. Two or more returned payments will result in my account being placed on a "cash or money order only" payment status. _____
- A receipt for income tax purposes will be provided. _____

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 or sanctioned by this center. This center shall remain harmless from any such arrangement. **Initial:** _____

Media Release

Occasionally, photos and videos will be taken of the children at the center for use with our program. Please indicate that you authorize the use and reproduction of photographs and videos of your child in conjunction with the program. **Initial:** _____

AGREEMENT

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

NAME OF CHILD		
FEE AMOUNT \$ 45	PER-DAY-WEEK Week	DAY PAYMENT TO BE MADE Friday before service
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
• PM snack		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE \$ 1	PER MIN-HR min	
Extra services to be provided at an additional fee if applicable		

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. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR

DATE

SIGNATURE-PARENT OR GUARDIAN

DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN

DATE

Facts About My Child

Before and After School Program

Child's Name: _____ Grade _____ Age _____

Family Information

Parents'/Guardians' Names: _____

Address: _____

Home Phone Number: _____

Mom Cell: _____ Mom work phone: _____

Dad Cell: _____ Dad work phone: _____

Email of Primary Contact: _____

Please list the persons living in your household (siblings, extended family, etc....)

Are there any family traditions, cultural or religious customs that you observe?

Changes in families affect children in many ways. Have there been any changes in your family in the last year? Do you anticipate any big changes in the upcoming year? How does your child react when things change? _____

Please list any previous group experiences (child care, play groups, church, etc.) What were his/her experiences like there? _____

Health Information

Please list any factors which may influence your child's comfort or adjustment to school/care (e.g. language problems, physical disability, vision, or hearing problems, etc.) _____

Does your child have any allergies (food/medications/seasonal/pets or environmental)?

Sensitive skin/rash tendencies? _____

CHILD PICK-UP AUTHORIZATION

Before and After School Program

I, _____, authorize A Brighter Day Learning Center to release my child: _____ to the person(s) designated below.

NOTE: Parents and guardians should designate themselves as designated custodians. Friends, neighbors and other relatives may also be designated. PLEASE PRINT CLEARLY.

Name	Relationship	Address

Parent Signature

Relationship

Date

Print Parent Name

(Home Phone) _____ (Work) _____ (Cell) _____

Name of Child: _____

A Brighter Day Learning Center

Child Emergency Contact Information and Consent Form (Before and After School Program)

Child's Name: _____ Birthdate: _____

Address: _____

Parent or Guardian #1: _____

Telephone: Home _____ Work _____ Cell Phone _____

Parent or Guardian #2: _____

Telephone: Home _____ Work _____ Cell Phone _____

Emergency Contacts (to whom your child may be released to when parent or guardian cannot be reached)

Name #1: _____ Relationship: _____

Address: _____

Telephone: Home _____ Work _____ Cell Phone _____

Name #2: _____ Relationship: _____

Address: _____

Telephone: Home _____ Work _____ Cell Phone _____

Written permission must be on file for anyone other than a parent/guardian to pick up your child from the center.

Child's Primary Medical Care

Physician's Name: _____ Phone #: _____

Address: _____

In case of an emergency, hospital to take your child: _____

Child's Health Insurance

Name of Insurance Plan: _____

Certificate Number (or ID) #: _____ Group #: _____

Policy Holder's Name: _____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations:

Parent/Legal Guardian Consent and Agreement for Emergencies

As parent/guardian, I give consent to have my child receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I agree to review and update this information whenever a change occurs and at least once a year.

Parent/Guardian #1 Signature: _____ Date: _____

Parent/Guardian #2 Signature: _____ Date: _____

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](http://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:

ADDRESS:

PHONE:

SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT

TITLE:

LICENSE NUMBER:

DATE FORM SIGNED:

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

A Brighter Day Learning Center Before and After School Program

EMERGENCY PLAN COMMUNICATION FOR PARENTS/GUARDIANS

Parents and guardians need to be informed of provisions in the Emergency Plan. This letter will provide the information that they need. A copy of this letter should be given to parents of newly enrolled children, and at least once per year to all parents.

To the Parent (s)/Guardian (s) of _____:

This letter is to assure you of our concern for the safety and welfare of children attending A Brighter Day Learning Center. **Our Emergency Plan** provides for response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- *Immediate evacuation:* Students are evacuated to a safe area on the grounds of the facility in the event of a fire, etc.
- *In-place sheltering:* Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the building is the best immediate response.
- *Evacuation:* Total evacuation of the facility may become necessary if there is a danger in the area. In this case, children will be taken to a relocation facility. We currently have 2 available, they are:
 - Emergency Relocation Facility A at Worthington West Franklin Fire Dept.
 - Emergency Relocation Facility B at the Belmont Complex.

If it ever becomes necessary to relocate, a sign will be posted on the door stating which facility we've gone to (A or B).

If you're not sure how to get there, please ask for directions before there is an emergency.

- *Modified Operation:* May include cancellation/postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems (such as utility disruptions) that make it unsafe for children, but may be necessary in a variety of situations.

Please listen to WPXI, KDKA or www.abrighterdaycenter.org for announcements relating any of the emergency actions listed above. We ask that you not call during the emergency. This will keep the main telephone line free to make emergency calls and relay information.

The form designating persons to pick up your child is included with this letter for you to complete and have returned to the Child care facility no later than the first day of care. This form will be used every time your child is released. Please ensure that only those persons you list on the form attempt to pick up your child.

**Armstrong School District
Transportation Department
Busing Request**

Please complete all the information that applies and return as soon as possible for approval to:

Armstrong School District, Administration Office,
181 Heritage Park Drive, Suite 2, Kittanning, PA 16201
Attention: Mr. Jon Fair, Transportation Director
Phone 724-548-6014 Fax 724-548-7201

Full Name of Child	School	Grade
Parent/Guardian Name:		Date of Request:
Address:		
City:	State:	Zip:
Home Phone:		Cell Phone:
Current Bus Number/Location (AM)		
Current Bus Number/Location (PM)		
Please check one: <i>New Student</i> <i>School Bus Change</i> <input type="checkbox"/> <i>Bus Stop Change</i> <input type="checkbox"/> <i>Delete Student</i> <input type="checkbox"/>		
Give specific information/reason for request:		
Requested Bus Number/Location (AM)		
Requested Bus Number/Location (PM)		
Requested Start Date:		
If bus stop is at a babysitter or daycare, please give the following information:		
Name of babysitter/daycare: <i>A Brighter Day Learning Center (Harvest Community</i>		
Address: <i>143 Reed Road</i> <i>Church</i>		
City: <i>Kittanning</i>	State: <i>PA</i>	Zip: <i>16201</i>
Phone: <i>724-548-5643</i>		

Office of Transportation use ONLY

Approved: <input type="checkbox"/>	Signature/Date:		
Location (AM):	Bus Number:	Time:	
Location (PM):	Bus Number:	Time:	
Start Date:			
Disapproved: <input type="checkbox"/> Reason:			

Original: Transportation Department Copy to: Parent, School, Bus Contractor(s)
Approved changes will not take place until all parties have been notified Rev 10/15



143 Reed Road, Kittanning, PA 16201

724.548.5643

www.abrighterdaycenter.org

Sun Block Consent Form Before and After School Program

Child's Name _____

I give my permission for A Brighter Day Learning Center to apply sun block to my child _____ when he/she is going outside.

I will supply sunscreen or sun block with UVA and UVB of SPF 15 or higher.

I will replace the sunscreen when expired.

Parent signature _____ Date _____

Center Copy. Please sign and return.

Family Handbook Acknowledgement

This is a copy of the form you signed acknowledging that you have read the Family Handbook and agree to follow the Center's procedures.

This policies and procedures in this handbook are subject to change at the discretion of the Center's Board of Directors.

Thank you for your acknowledging the policies and procedures we have established for the safety and welfare of all children in our care. We look forward to getting to know you and your family.

I have received the [A Brighter Day Learning Center Family Handbook](#), and reviewed it with a member of [A Brighter Day Learning Center](#) staff. It is my responsibility to understand and familiarize myself with the Family Handbook and to ask center management for clarification of any policy, procedure or information contained in the [A Brighter Day Learning Center Family Handbook](#) that I do not understand.

Recipient Signature

Date

Center Staff Signature

Date



CACFP Infant Enrollment Form

Center/Provider Name: _____

Dear Parent/Guardian,

This childcare center/provider participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires childcare centers/providers to follow specific meal patterns according to the age of the infant.

Childcare centers/providers participating in the CACFP **are required** to offer at least one iron fortified infant formula for infants who are enrolled in care. You may decline the infant formula offered, and supply breast milk and/or your own CACFP approved iron-fortified formula.

(NOTE: A CACFP approved iron-fortified formula must have 1 mg of iron or more per 100 calories of formula when prepared using the label directions and must be regulated by the FDA.)

Additionally, when you determine, in consultation with your physician, that your infant is developmentally ready, the childcare center/provider will also be **required** to offer iron fortified infant cereal and other infant foods.

Infant's Name _____ Infant's Date of Birth _____

Iron Fortified Formula offered by the Center/Provider _____

Breast milk and/or Formula preference

Record date to indicate your preference (choose all that apply) <small>*I understand that I may change my decision at any time with advance notice</small>	Birth -5 months Date & Initial	6 – 11 months Date & Initial
I will provide expressed breast milk for my infant.		
I will breast feed my infant on site at the center/provider.		
I want the childcare center/provider to provide the infant formula it offers for my infant.		
I will provide the infant formula for my infant. (must be iron fortified) Name of infant formula I will provide: _____		
My infant has a special dietary need that requires a formula that does not meet the criteria for an approved iron fortified formula. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, and the recommended substitution. Name of infant formula I will provide: _____		

Preference regarding infant cereal and other foods

Record date to indicate your preference *I understand that I may change my decision at any time with advance notice	6 – 11 months Date & Initial
I want the childcare center/provider to provide the iron fortified infant cereal and other foods for my infant.	
I want the childcare center/provider to provide all food items with one exception. (This option is only applicable if center/provider is providing the iron fortified infant formula) One food item that I will provide (must be a creditable CACFP food item): _____	
My infant has a special dietary need that requires modifications to the infant meal pattern requirements. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant’s diet, how it effects the infant, the foods to avoid and the recommended substitutions	
I am aware and understand the all information provided on this form and my ability to have my infant participate in the CACFP; however, I decline the infant formula and food offered by the center/provider and elect to furnish ALL infant formula and food for my infant. (Center/Provider may not claim meals for this infant)	

Parent/Guardian

Date

Center/Provider signature

Date

This supplemental infant form must be completed for all infants in care and must be maintained by center/provider and if applicable, a copy must be maintained by the Sponsoring organization

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:

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

(2) Fax: (202) 690-7442; or

(3) E-mail: program.intake@usda.gov.
This institution is an equal opportunity provider.

**Child and Adult Care Food Program
Child Enrollment Form (Sample)**

Sponsor/Center Name: _____

Agreement #: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

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	<input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____ Enrollment Date: _____ Withdrawal Date: _____								<input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME										
BIRTH DATE										
AGE										
SECOND CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____ Enrollment Date: _____ Withdrawal Date: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME										
BIRTH DATE										
AGE										
THIRD CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____ Enrollment Date: _____ Withdrawal Date: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME										
BIRTH DATE										
AGE										

Signature _____

Signature of Parent or Guardian

Date _____

Telephone Number of Parent or Guardian _____

CHILD CARE REPRESENTATIVE USE ONLY:	_____	_____
	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.		

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:

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

(2) fax: (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)

Child's First Name	MI	Child's Last Name	Foster/Child	Migrant	Runaway	Homeless	Head Start
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

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.

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

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.

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?		Welfare/Child Support/Alimony		How often?		Pensions/Retirement/Social Security/SSI/VA Benefits		How often?	
	Weekly	Bi-Weekly	Monthly	2x-Monthly	Weekly	Bi-Weekly	Monthly	2x-Monthly	Weekly	Bi-Weekly	Monthly	2x-Monthly
	\$				\$				\$			
	\$				\$				\$			
	\$				\$				\$			
	\$				\$				\$			

Total Household Members (Children and Adults) Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member

Check if no SSN

STEP 4 Contact information and adult signature. 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

Address

City

State

Zip

Phone/Email

Signature of Adult

Today's Date

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> A friend or extended family member regularly gives a child spending money
Income from any other source	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Salary, wages, cash bonuses Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> 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 **Household size**

How often? Weekly Bi-Weekly Monthly 2x/Month

Eligibility Free Reduced Denied

Determining Official's Signature Date

Confirming Official's Signature Date

Follow-up Official's Signature Date