Lower Elwha Child Care

PLEASE PRINT LEGIBLY CHILD REGISTRATION FORM

STUDENT INFORMATION

child's Legal Last Name:	Legal First Name:	Legal Middle Name:	Also known as:	Gender: ☐ Male ☐ Female	age

Birth Date: _____/_____/_____ Mo Day Year

What language did your child first learn to speak? ☐ English ☐ Other

Parent's first language:

Do you need an interpreter (e.g. for school meetings)? Yes ☐ No ☐

Do you need official school materials to be translated? Yes ☐ No ☐

PRIMARY HOUSEHOLD INFORMATION (WHERE THE STUDENT RESIDES)

Child lives with: (circle) Both Parents Mother Father Father/Stepmother Mother/Stepfather

Foster Parents Legal Guardian Grandparent(s) Alternates Parents Emancipated Minor

Other (specify relationship) _____

Child's Physical Residence: Street: _____ Apt. # _____

Complex: _____ City: _____ State: _____ Zip: _____

Family Mailing Address (if different): Street/PO Box#: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Is this a temporary living situation? ☐ Yes ☐ No

If yes, please indicate below where the student is living

☐ In a shelter ☐ In a car ☐ In a motel/hotel ☐ With more than one family in a house or apt.

☐ With friends or a relative

☐ Other _____

HOUSEHOLD 1 – GUARDIAN 1

Parent/guardian **living with** child: Last Name: _____ First Name: _____

Relationship: _____ Email: _____ Employer: _____

Phone: (_____)_____ Home Phone ☐ **Confidential?** Phone: (_____)_____ Work Phone Phone: (_____)_____ Cell Phone/Other Phone

HOUSEHOLD 1 – GUARDIAN 2

Parent/guardian **living with** child: Last Name: _____ First Name: _____

Relationship: _____ Email: _____ Employer: _____

Phone: (_____)_____ Work Phone Phone: (_____)_____ Cell Phone Phone: (_____)_____ Other Phone

SECONDARY HOUSEHOLD INFORMATION

HOUSEHOLD 2 – GUARDIAN 1

Parent/guardian **not living with** child: Last Name: _____ First Name: _____

Mailing Address: Street/PO Box#: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Relationship: _____ Email: _____ Employer: _____

Phone: (_____)_____ Home Phone ☐ **Confidential?** Phone: (_____)_____ Work Phone Phone: (_____)_____ Cell Phone/Other Phone

HOUSEHOLD 2 – GUARDIAN 2

Parent/guardian **not living with** child: Last Name: _____ First Name: _____

Relationship: _____ Email: _____ Employer: _____

Phone: (_____)_____ Phone: (_____)_____ Phone: (_____)_____
Work Phone Cell Phone Other Phone

CUSTODY INFORMATION

Release child to noncustodial parent? ☐ Yes ☐ No
Is there a joint custody or parenting plan in effect? ☐ Yes ☐ No If yes, plan must be on file with the school for enforcement.
Is there a restraining order in effect? ☐ Yes ☐ No If yes, legal papers must be on file with the school for enforcement.

Restraining order is against: ☐ Mother ☐ Father ☐ Other - Name: _____

EMERGENCY INFORMATION

Persons to contact in case of **emergency** (if parent/guardian cannot be reached) **and** who **<u>are authorized to pick up child</u>**:

Name: _____ Relationship: _____

Phone: (____) _____ Phone: (____) _____

Name: _____ Relationship: _____

Phone: (____) _____ Phone: (____) _____

Name: _____ Relationship: _____

Phone: (____) _____ Phone: (____) _____

Name: _____ Relationship: _____

Phone: (____) _____ Phone: (____) _____

Medical Emergency Information: Physician: _____ Phone: (____) _____

Please describe any health conditions or allergies the child care center should be aware of:

_____

Persons who **DO NOT** have authorization to pick up child:

Name: _____ Relationship: _____

Phone: (____) _____ Phone: (____) _____

Name: _____ Relationship: _____

Phone: (____) _____ Phone: (____) _____

Child's Ethnicity/Race

Part 1: Is your child of Hispanic or Latino origin? Yes ☐ No ☐

Part II: What race(s) do you consider your child? (check all that apply)

☐ African American/Black	☐ White	☐ Alaska Native	☐ Chehalis	☐ Hoh
☐ Jamestown	☐ Lower Elwha	☐ Lummi	☐ Makah	☐ Muckleshoot
☐ Port Gamble	☐ Puyallup	☐ Quileute	☐ Skokomish	☐ Tulalip
☐ Upper Skagit	☐ Asian	☐ Native Hawaiian	☐ Samoan	☐ Other Pacific Islander
Other Tribe _____				

Child's Health Information

Date of last physical exam:

Child's health care provider:

Phone number

Regular medications yes or no? If yes, specify.	Allergies, including drug reactions yes or no? If yes, specify.
Child's dentist's name	Phone number
Insurance company name	Member/policy number
Policy holder name	Employer name

Mother/Guardian			Father/Guardian		
First Name	Last Name		First Name	Last Name	
Lives with Child Y N	Legal Custody Y N	Date of Birth / /	Lives with Child Y N	Legal Custody Y N	Date of Birth / /
Marital Status [ ]Married [ ]Single [ ]Separated [ ]Divorced [ ]Widowed			Marital Status [ ]Married [ ]Single [ ]Separated [ ]Divorced [ ]Widowed		
Do you receive Child Support? [ ] Yes [ ] No If yes, amount per month $			Do you receive Child Support? [ ] Yes [ ] No If yes, amount per month $		
Race: **American/Alaskan Indian** [ ] Lower Elwha [ ] Hoh [ ] Jamestown S'Klallam [ ] Lummi [ ] Makah [ ] Muckleshoot [ ] Port Gamble [ ] Quileute [ ] Quinault [ ] Samish [ ] Skokomish [ ] Swinomish [ ] Tulalip Other _____ [ ] Black/African American [ ] White [ ]Asian [ ]Biracial/ Multi-Racial [ ]Native Pacific Islander/Hawaiian Other:_____			Race: **American/Alaskan Indian** [ ] Lower Elwha [ ] Hoh [ ] Jamestown S'Klallam [ ] Lummi [ ] Makah [ ] Muckleshoot [ ] Port Gamble [ ] Quileute [ ] Quinault [ ] Samish [ ] Skokomish [ ] Swinomish [ ] Tulalip Other _____ [ ] Black/African American [ ] White [ ]Asian [ ]Biracial/ Multi-Racial [ ]Native Pacific Islander/Hawaiian [ ]Other:_____		
Employment Status: [ ] Employed [ ] Seasonally Employed [ ] Unemployed [ ] Retired [ ] Seeking Employment [ ] Disabled [ ] Incapacitated [ ] Other_____ Dates incapacitated From_____ To_____			Employment Status: [ ] Employed [ ] Seasonally Employed [ ] Unemployed [ ] Retired [ ] Seeking Employment [ ] Disabled [ ] Incapacitated [ ] Other_____ Dates incapacitated From_____ To_____		
Employer Name	Employer Phone		Employer Name	Employer Phone	
Employer Name	Employer Phone		Employer Name	Employer Phone	
Work Schedule (include all jobs) Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____			Work Schedule (include all jobs) Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____		
Pay Days are [ ] Weekly [ ] Every 2 Weeks [ ] Twice per Month [ ] Monthly Gross Income $_____ Per _____			Pay Days are [ ] Weekly [ ] Every 2 Weeks [ ] Twice per Month [ ] Monthly Gross Income $_____ Per _____		
Do you receive TANF or GA, or SSI [ ] Yes [ ] No If yes, amount per month $_____			Do you receive TANF, GA, or SSI [ ] Yes [ ] No If yes, amount per month $_____		
Do you have any additional sources of income? [ ] Yes [ ] No If yes, amount per month $_____ Description:_____			Do you have any additional sources of income? [ ] Yes [ ] No If yes, amount per month $_____ Description:_____		
Are you in School or Training? [ ] Yes [ ] No			Are you in School or Training? [ ] Yes [ ] No		
School Name	School Phone		School Name	School Phone	
School/Training Schedule (where will you be while child is in child care?) Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____			**School/Training** Schedule (where will you be while child is in child care?) Monday _____ Thursday _____ Tuesday _____ Friday _____ Wednesday _____ Sat/Sun _____ Total Hours Per Week: _____		

Payment Source
Will you be paying the full amount of your child care cost? [ ] Yes [ ] No (if yes skip to the next page) Have you applied for the Washington State Child Care Subsidy Program through DSHS**?** [ ] Yes [ ] No **Do you receive child care subsidy?** [ ] Yes [ ] No If yes which one? [ ] Working Connections [ ] DSHS [ ] CPS [ ] TANF [ ] Other_____

Only answer the following questions **if** you **have already** signed up for DSHS **child care subsidy** program and **been denied:**

CCDF Subsidy Eligibility

To be eligible for Child Care and Development Fund subsidy program, the family must fill out this entire enrollment packet including household income size and income information. The family must first apply for Washington State Child Care Subsidy Program.

Have you been denied by DSHS child care Subsidy?

[ ] Yes [ ] No (if no please apply for DSHS childcare subsidy program)

The child must be age eligible:

To be eligible for services, children must: (1) be under the age of 13.

Is the child under 13 years of age? [ ] Yes [ ] No

The child must be Native American:

(2) A Native American Child that is enrolled or eligible for enrollment in a federally recognized Tribe, or a child of a parent or grandparent enrolled in a federally recognized tribe, or a child/stepchild or adoptive child of a parent or grandparent enrolled in a federally recognized tribe.

Is the child or someone caring for the child (Parent, Grandparent, Stepparent, Adopted parent/grandparent) enrolled or eligible for enrollment in a federally recognized tribe? [ ] Yes [ ] No

The Household Size and Income must not exceed 85% of State Median Income:

(3) reside with a family whose income does not exceed 85 percent of the State's median income for a family of the same size;

Lower Elwha Child Care Staff will calculate and answer this question

The child must reside with parent/loco parentis:

(4) reside with a parent(s) or someone acting in loco parentis who is working or attending job training or an educational program or receiving or needs to receive protective services.

Is the parent (or acting parent) working, attending job training, or educational program, or needs/receives protective services? ? [ ] Yes [ ] No

Lower Elwha Childcare
Child Care Agreement

	First Name	Middle Name	Last Name
Child's Name:			
	First Name	Middle Name	Last Name
Parent or guardian's Name:			

Days and times my child will receive care:

Check day(s) of care	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
Arrival Time					
Departure Time					

FEE: $_____ per ☐ Hour ☐ Day ☐ Week ☐ Month

Date Payment Due:

Source of payment
☐ Parent
☐ Other (specifically):

Overtime rate: $ 1 per child per minute

Late fee: $25 Per Month

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I agree that if I leave without paying my balance after 30 days I can be sent to collections. I understand and agree that I will be financial responsible for all costs charged to the child care center by the collections agency.

I have read, understand, and agree to comply with the policy and procedures, information for parents given

to me by _____
NAME OF PROVIDER

PARENT OR GUARDIAN'S SIGNATURE	DATE	PARENT OR GUARDIAN'S SIGNATURE	DATE

I agree to provide child care service according to the above plan. I agree to promptly notify the parent(s) or guardian(s) of any changes to the above information.

PROVIDERS SIGNATURE	DATE

STREET ADDRESS	CITY	STATE	ZIP CODE

COMMENTS

Agreements

I _____agree to transport my child, to and from child care, in an approved car seat for his/her age and/or weight limit, until they are 8 years old or 4'9". I agree to transport my child in the back seat until the child is over 13 years of age, in accordance with Washington State and Lower Elwha Klallam Tribal law enforcement safety and transportation laws.

I also agree to be responsible and pay in full, any balance incurred for services if DSHS/CCDF doesn't cover part or all of my child's care.

I also understand that if I am receiving State subsidy coverage for hours I'm not attending school or work will be billed as private pay.

I agree to pay all balances and co-pays in full before my child's last day of care.

If I am a tribal employee, I give the tribe permission to withhold the balance owed to Lower Elwha child care, from my paycheck, the pay period after I withdrawal my child, or I have stopped brining my child to the program for 30 days.

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application.

_____

Parent/Guardian Name (please print)

_____

Parent/Guardian Signature Date

_____

Staff Member Name Title Date

Child's name: _____

Lower Elwha Child Care Center

Permission Form:

Initial

_____ 1. I give permission for my child _____ to take part in planned and spontaneous field trips away from the Child Care Center.

_____ 2. I give permission to the child care for my child to participate in activities at the Child Care Center, including holiday festivities.

_____ 3. I give permission for my child to be transported by automobile or public transportation.

_____ 4. I give permission for my child to have routine health screenings, hearing, vision, teeth and general physical health.

_____ 5. I give permission for my child to have their picture taken, individually or in a group setting, for record keeping, display on the classroom and general public.

_____ 6. I authorize the Lower Elwha Child Care Center staff to administer first aide; take my child t the nearest emergency center; or summon an ambulance for emergency medical care when necessary. If an emergency arises, I understand I will be notified as soon as possible. I will be responsible for all cost incurred for each service.

_____ 7. I do herby waive, absolve, release, indemnify and hold harmless the staff or any person aiding the staff, for any accident or injury sustained by my child while enrolled at the Center or while be transported to or from the Center, except to the extent covered by liability insurance carried by the Tribe for the center.

_____ 8. I have had the parent handbook of the Lower Elwha Child Care Center explained to me; I fully understand its contents and agree to abide by them. A copy of the handbook has been given to me for my records.

_____

Parent's Signature Date

_____

Parent's Signature Date

_____

Child Care Staff Signature Date

PARENT SIGNATURE FORM

This health policy is a description of **our** health and safety practices.

Staff will be oriented to our health policy by ***Director***, ***Annually in September and at hire.***

Our policy is accessible to staff and parents and is located ***on bulletin board in all classrooms and on parent information board in main entry way***.

I understand and will abide by the health policy book. I have had the Health Policy Book explain to me. I understand the Health Policy Book and will abide by it. I also know that I can reference this book at any time and it is located in the main entry on the parent bulletin board.

_____ _____

Parent signature Date

_____ _____

Parent Signature Date

_____ _____

Lower Elwha Child Care Staff Date

Effective Date and Review Date:

This policy is effective ____/____/_____ and will be reviewed annually or as needed.

PLEASE MAKE A COPY TO SIGN AND BE PLACED IN CHILDS FILE.

Natural Disasters and Emergency Management Plan

Policy

The Lower Elwha Childcare will have in place a comprehensive disaster management plan.

Procedures

- In any emergency that causes injuries, closest staff will call 911 and care for injuries.
- In the event of an emergency requiring evacuation during childcare hours, children will be bused to the Lower Elwha Police Station. Each classroom will load in a van with an appointed emergency crew member from tribal center along with their lead teacher; children, teachers, a designated driver, and one Manager will be on each van. Teachers will do roll call to ensure all children are accounted for.
- During evacuation of the building the manager will check each classroom and corresponding restroom(s) to ensure all children are evacuated. Van drivers will have cell phone available on the van.
- The Manager will notify Emergency Operations contact as soon as possible, reporting all children, staff, and volunteers clear of danger.
- Teachers will utilize contact lists maintained on each van to contact parents/guardians. As children are reunited with family, time and name of person taking custody will be documented on release form.
- Children that are not reunited with family will be housed at the Emergency Shelter (Lower Elwha Police Station) until appropriate custody is established.
- Each classroom will have a disaster kit with the following contents:
  - food,
  - bottled water,
  - AM/FM radio for news updates,
  - a whistle to use as a locator,
  - plastic bags to keep clothing dry,
  - emergency blankets for warmth.
- In the event of an emergency that does not require evacuation of the building, but children are not able to be transported at the end of the class day, disaster kits will be utilized as needed to provide basic needs.
- Lead teachers will be responsible for their students until each child is released or the Manager, or Director releases them from duty.
- Staff will receive annual pre-service training/information on disaster management. Parents/guardians will be informed of procedures at enrollment orientation.

Updated

Parent Signature/Date

Staff Signature/Date

The Lower Elwha Klallam Tribe

ʔəʔɬx̣ʷə nəxʷsƛ̓ayəm - "THE STRONG PEOPLE"

Child Care Center

Dietary Restrictions/ Food Allergy/Intolerance

Date_____

Child's Name_____

Medical Reason for the child not be served food/milk:

_____

_____

_____

_____

What to substitute in place of food/milk:

_____

_____

Printed Name of Medical Authority

_____

Signature of Medical Authority

A recognized medical authority, for the purpose of identifying the need for food substitutions in children's meal and for recommending alternate foods, is defined as one of the following health care professionals:

- **A physician, either a M.D. (Medical Doctor) or a D.O. (Doctor of Osteopathy).**
- **A licensed physician's assistant who is licensed to a physician and has prescriptive authority.**
- **An advanced licensed registered nurse practitioner (ARNP) who has prescriptive authority**
- **A licensed Naturopathic Physician mention in the law related to nursing care.**

Request for Fluid Milk Substitution – Child Care

Child's Name _____

Non-dairy milk substitution request:

If your child cannot drink cow's milk due to medical or other special dietary needs but does not have a diagnosed medical disability, your provider may choose, but is not required, to provide a non-dairy milk substitute that is nutritionally equivalent to cow's milk, based on your request. At this time, only four brands of non-dairy milk substitutes available in Washington meet the definition of being nutritionally equivalent to cow's milk: 8th Continent Soymilk (Original and Vanilla), Pacific Ultra Soy (Original and Vanilla), Great Value Original Soymilk and Kirkland Organic Soymilk (Plain).

By completing the information below, your child may be served one of these soy milks, provided by the child care facility (if the child care facility chooses), or provided by you.
Identify why your child needs a non-dairy milk substitute: _____

_____

_____ I request my child be served the child care facility provided soy milk as described above for meals that require milk.

_____ I will provide one of the soy milks described above for meals served to my child that require milk.

Providers are required to serve a milk substitution that is nutritionally equivalent to cow's milk if your child has a documented medical disability, diagnosed by a licensed physician, either a M.D. (Medical Doctor) or a D.O. (Doctor of Osteopathy). If your child has been diagnosed with a medical disability that prevents the child from consuming cow's milk or one of the approved soy milks listed above, submit a note from the physician identifying the following:

1) The child's disability
2) The major life activities/bodily functions affected by the disability
3) A description of how the disability restricts the child from drinking cow's milk and approved brands of soymilk
4) The prescribed food substitute

Cow's milk substitution request:

Providers may choose, but are not required, to serve lactose-reduced or lactose-free milk or organic milk to children in their care. If the provider does not serve these milks, the parent may bring the substituted milk for their child to consume while in care.

_____ I request my child be served the child care facility provided 1% or nonfat lactose-reduced or lactose-free milk. (Whole lactose-reduced or lactose-free milk if the child is 12 to 24 months)

_____ I request my child be served the child care facility provided 1% or nonfat organic milk. (Whole organic milk if the child is 12 to 24 months)

Signature of Parent/Guardian: _____ Date: _____

Public Health
Seattle & King County

Diaper Cream/Ointment Authorization Form

Child's Name:	**Date of Birth/Age:**
Name of Medication:	
Start Date:	**Stop Date: (up to 6 months after 'start date')**
Apply topically: ☐ when rash is present ☐ with every diaper change ☐ other:	**Amount to be applied:**
Possible side effects:	☐ **Above information consistent with label?**
Special Instructions:	

For diaper rash prevention or treatment.
Store at room temperature.

_____ _____

Parent/Guardian Signature **Date**

_____

Daytime Phone Number

_____ _____

Physician Signature* **Date**

_____

Physician Phone Number

* Necessary only for diaper creams/ointments not labeled for use in the diaper area. (Pharmacist label on prescription medication indicates consent of health care provider.)

Diaper Cream/Ointment Application Record

(Must be filled out by the person who applies the cream/ointment)

Child's Name:
Name of Medication:

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

List any side effects and date below. Notify parent/guardian immediately.

Signatures (& initials) of persons applying cream/ointment:

_____ ( ) _____ ( )

_____ ( ) _____ ( )

_____ ( ) _____ ( )

Early Achievers: Parent/Guardian Consent for On-Site Evaluation

Dear Families:

As you know, _____ is participating in an exciting new program called **Early Achievers**. We need your help to make this effort a success! Please read below for more information on how you can help us continue to provide high-quality care that helps children learn and grow.

Early Achievers is a voluntary program that:

- Provides families with information about the quality of care through a Level 1 through 5 rating system
- Offers child care programs resources like coaching and training so they can support children's learning and development

On-Site Evaluation:

Child care programs that participate in Early Achievers receive **on-site evaluation** visits from the **University of Washington (UW)**. The purpose of the evaluation visits is to observe and gather information about the program in order to create an **Early Achievers Rating**.

_____has invited the UW evaluation team to visit a random selection of its classrooms as part of the Early Achievers rating process. Your child's classroom may be chosen and observed to help the rating team measure the quality of care provided at _____.

This process includes collecting information that will be used to create a program rating and can be used in the next phase of Early Achievers to improve the quality of care provided for your child, like:

- Observing the child care environment to learn about the materials, activities and experiences available to support children
- Observing interactions between teachers and children
- Audiotaping teachers' language to understand the amount and type of language your child's teacher uses
- Observing children engaging in the classroom to understand how the environment stimulates children's learning
- Interviewing teachers and directors about how they use their practice to support their young children
- Interviewing interested families to learn about how the facility staff partner with families to supports their child's learning and development

- Reviewing program files and documentation to learn how program policies and procedures support quality practice
- Reviewing child files to see how the program supports each child's learning and development

Please note:

- Your child's care and education will not be interrupted or altered during this process.
- One Early Achievers rating will be assigned for each participating child care program. Information about your facility's participation will be posted on the Department of Early Learning and Child Care Aware of Washington websites.
- Any information that is made publically available as part of Early Achievers will never include information about your specific child.
- **No identifiable information about individual children will be collected**

Please let us know if your child's files can be included during the evaluation visit.

- ☐ **I allow my child's files to be reviewed as part of the facility evaluation as outlined above**
- ☐ **I would like my child's files to be excluded during this process**
  - Reason (*optional*): _____

Child care facility name: _____ **Classroom:** _____

Child name: _____

Parent/Guardian name (printed): _____

Signature: _____ **Date:** _____

Optional: The UW Evaluation Team would like to hear what you think about how your child care program works with children and families. If you are interested in participating in an interview with the UW team, please indicate below:

- ☐ Yes, I am interested and willing to be contacted by UW for an interview
  (Note: *not all families who check yes will be contacted)*
- ☐ Please contact me by phone

  Phone number _____

  Best time to reach me _____
- ☐ Please contact me by email so I can access a link to an online parent survey

  Email address _____

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the SSN is not needed.

"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."

Signature of Adult	Today's Date	Print Name of Adult Signing
X______________________________	______________	**Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN

Address	City/State/Zip Code	Daytime Phone

PART 6 – 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 ☐ Multi-Racial
☐ Native Hawaiian or 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 Basic Food, 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

EMAIL: program.intake@usda.gov

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

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on Basic Food/TANF/FDPIR.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free
☐ Reduced-Price
☐ Above-Scale

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Institution's Representative **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.

EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.