THE ACADEMY OF YOUNG SCHOLARS
YOUR CHILD'S HAPPY PLACE!

Distribution
. Child's File

Enrollment Application

Child

Entrance Date:___/___/___
Child's Name:_____Age:_____
Childs Home Address_____
Phone Number_____
Birthdate:_____
Gender:_____
Hours Needed_____

Parents/Guardian:

Mother's Name:_____
Address:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Place of
Employment_____
Place of Employment Address_____

Father's Name: _____
Address:_____
Home Phone:_____Cell Phone: _____
Work Phone: _____Email:_____
Place of
Employment_____
Employment Address _____

Child's Legal Guardian:_____
( ) Both Parents
( ) Mother
( ) Father

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child to the center's designated emergency facility.
Memorial Herman Memorial City Medical Center, 921 Gessner Rd, Houston, TX, 77024 (832)227-1000

List any special problems your child may have, such as allergies, existing/ previous illness in the past 12 months, medication, and any other information which caregiver's should be aware of:

Medical:_____
Allergies:_____
Name of Primary Physician:_____
Address:_____
Phone #_____

_____ I give consent for the facility to secure any and all necessary emergency medical care for my child, and for necessary treatment when my child is in the care of a licensed Physician, Emergency Room, or Hospital. I agree to hold harmless and release The Academy Of Young Scholars Harris County TX, from all liability. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

(Parent/Guardian Signature) _____
(Date) ___/___/____

(Parent/ Guardian Signature)_____
(Date) ___/___/____

Academy of Young Scholars will notify parents if a notifiable disease has been introduced into the center.

_____ 10. I understand that The Academy of Young Scholars while is independently owned and operated and The Academy of Young Scholars whose name appears at the heading of this form is responsible for the actions or obligations of this center.

_____ 11. I understand the center closes at 6:30pm. I will incur late fees for the time my child spends at the center past 6:30pm. If I have not picked up my child by 7:00pm and all attempts to contact me and all of my emergency contacts fail, The Academy of Young Scholars will call Child Protective Services and the Police. See Parent Hand Book for details.

_____ 12. I understand that it is my responsibility to keep the center advised on changes of addresses, phone numbers, etc. in writing.

Signed :_____(Parent or Guardian)
Date: _____
Signed :_____(Director)
Date: _____

ADMISSION REQUIREMENT:

Child's Name:_____

TEXAS Health and Human Services

Form 2935
April 2023

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name:		Director's Name:	
Child's Full Name:	Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian *(if different from the child's)*:		
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance: ○ Yes ○ No | If no, what type of assistance is needed: _____

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯Yes ◯No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian **Date Signed**

School Age Children

My child attends the following school:	School Area Code and Phone No.:

My child has permission to *(check all that apply)*:

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

- ○ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- ○ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ○Pass ○Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				○ Pass ○ Fail
Left				○ Pass ○ Fail

Signature **Date Signed**

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. *(Select **only one** option.)*

- ○ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.
- ○ A signed and dated copy of a health care professional's statement is attached.
- ○ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- ○ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature | Date Signed

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

◯Positive ◯Negative Date:

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian | Date Signed

Center Designee | Date Signed

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature | Date Signed

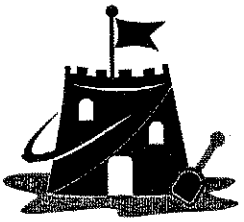

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Photo Release Policy

For the consideration of the opportunity to have my child's, voice, picture, portrait, artwork and or likeness published and for the good and valuable consideration, the receipt and sufficiency which are hereby acknowledge, the undersigned, on behalf of myself and my minor child, hereby agree as follows;

Photo Release Policy
Upon enrollment, I agree that I received a copy of the Photo Release Policy to read and sign. Many pictures will be taken in my child's class and throughout the center during the time that my child is at The Academy of Young Scholars. Other families and teachers may take snapshots of parties and special events within the program. These pictures may be printed and posted in a variety of ways or sent out to parents in the form of an email or the Brightwheel App. By enrolling my child in the center I consent that other parents whose children attend The Academy of Young Scholars may see my child's image. No names will be used on any photographs leaving the center. I am signing this release as a condition of enrollment.

If for any reason you do not want your child photographed, please let the Director or member of management know as soon as possible. Also, be sure you make the classroom teachers aware of your wishes.

Child's Full Name _____

Parent /Guardian Printed Name _____

Parent/Guardian Signature _____
Date ___/___/____

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Financial Terms and Enrollment Contract

1. Effective Date of Agreement:
This agreement will take effect on _____ and remain in effect. After each year, the application for your child/children will automatically be renewed unless the parent or guardian of each child/children provides a written statement notifying The Academy Of Young Scholars that our services are no longer needed.

2. Withdrawal or Status Change:
In the event I elect to change my child/children status or withdraw my child/children from The Academy of Young Scholars, I agree to provide 30 day advance written withdraw notice to the Director. I understand I will be responsible for the tuition for any reversal of status change or dis-enrollment that happens within a 30 day period until the last day of care. Additionally, if I choose to re-enroll my child/children, I agree to pay new application fees, new security deposits and all account balances as though my child/ children is a new enrollment. Please be advised that rules in the enrollment agreement is subject to change.

3. Final Placement:
A decision agreed by both parties The Academy Of Young Scholars, and parent or legal guardian on final placement will be made after contract is signed.

4. Application Fee:
I agree to pay a non-refundable application fee at the time of enrollment of ($**150.00**) per child. I also agree to pay an annual Curriculum Supply Fee every January 1st, April 1st, July 1st and October 1st of (**$25.00 quarterly equal to $100 per year), all fee's are non-refundable.** These fees allow us to ensure that our students have all the tools and supplies they need for a premium education. You may pay the annual fee in cash or an on line credit card payment through the Brightwheel app.

5. Security Deposit:
I agree to pay a security deposit of which is equal to one week of tuition the week prior to my child starting care.

6. **Payment and Terms:**
I agree to pay a weekly tuition rate due every Friday upon arrival of my child/children or online. This rate is subject to change and will be adjusted due to tuition increases. A (thirty 30) day prior written notice or scheduled status changes. After Friday late fees will apply. There will be a **$25.00** late charge applied to my tuition. If the full tuition plus late charges are not paid by close of business day (6:30 pm) on Friday my child will not be able to attend on Monday. If my account is not paid in full by Friday of that week, suspension of care may result without further notice. I understand if there is a necessary tuition increase, I agree to pay the additional increased amount after a (30) thirty day notification.

Academy of Young Scholars including, without limitation, any loss or injury sustained by my child or myself as a result of my child's participation in activities sponsored or conducted by The Academy of Young Scholars and/or it's employees, excluding only intentional torts performed by an employee of The academy of Young Scholars during time my child is in the care and custody of The Academy of Young Scholars.

16. Termination
Childcare maybe terminated by both agreed parties The Academy of Young Scholars, parent or legal guardian after 30 day written notification. Also, The Academy of Young Scholars reserves the right to immediately terminate a child/children(s) enrollment at its sole discretion for: 1. inappropriate conduct (as determined by **The Director and/or Owners**); by the child or parent, 2. when tuition is in arrears, 3. if the parent or legal guardian does not provide upon request a current written pediatrician's certification that a child is healthy and able to participate in The Academy of Young Scholars programs without exposing other children to various health risks.

17. Breastfeeding Policy:
The Academy of Young Scholars support the needs of breastfeeding mothers to provide milk to their babies. The Specific details can be found in the Breastfeeding Policy, located in the The Academy Of Young Scholars Handbook and policies and procedures.

18. Discrimination Policy:
The Academy of Young Scholars **does not discriminate against any child who has special needs. If a child has special needs we will request an Form 2603,STAR Kids Individual Service Plan (IEP) which provides for specialized instruction for students. Special service for young children with developmental delays. Or an Special Individualized Education (SpEd) which is written for a child with a disability. The school must first determine whether the child qualifies for special education services. To qualify the child's disability must have an adverse effect on the child's education progress.**

This Enrollment Agreement Contract will be governed by The Academy of Young Scholars and shall be applicable to and inure to the benefit of The Academy of Young Scholars affiliates and successors.

I have read, understand and agree to the above contract which represents part of my obligation to The Academy of Young Scholars. This agreement is subject to change by The Academy of Young Scholars upon thirty days notice.

Signatures

_____ Date_____
Parent/Legal Guardian Signature

NEW ☐ UPDATE ☐ DROP IN ☐ **Facility Name:** The Academy of Young Scholars **Facility ID:** 2327

ANITAM CE: 0
CHILD ENROLLMENT FORM

IMPORTANT NOTICE: Your daycare facility participates in the US Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participants will receive nutritious meals and snacks at no cost to you. This fom must be completed by a parent or guardian at the time of enrollment and must be updated yearly. Failure to complete the enrollment form will result in non-payment for this child's meal.

Child's Name:_____ Date of Birth:_____ Age:_____

Sex ☐ Male ☐ Female Food Allergies: ☐ Yes ☐ No If "yes", specify:_____ **A doctor's note must be provided.**

Days Normally in Care: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Meals/Snacks Normally Served: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner ☐ Evening Snack

Original Start Date:_____

Arrival and Departure Times: **Arrive**_____ ☐ AM ☐ PM **Depart**_____ ☐ AM ☐ PM

Withdrawn Date:_____

RACE OF CHILD: You are NOT required to answer this question:

☐ White ☐ Black or African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's Name:_____ Date of Birth:_____ Age:_____

Sex ☐ Male ☐ Female Food Allergies: ☐ Yes ☐ No If "yes", specify:_____ **A doctor's note must be provided.**

Days Normally in Care: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Meals/Snacks Normally Served: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner ☐ Evening Snack

Original Start Date:_____

Arrival and Departure Times: **Arrive**_____ ☐ AM ☐ PM **Depart**_____ ☐ AM ☐ PM

Withdrawn Date:_____

RACE OF CHILD: You are NOT required to answer this question:

☐ White ☐ Black or African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Infant Decline Statement

Similac Advance w/Iron is the formula this facility offers for infants through CACFP. It is your choice whether or not to use this formula based on your infant's needs. Baby foods provided by this facility must be in compliance with the infant meal pattern

To be completed by facility

Please make your preferences _____ **Today's Date**

I will bring expressed breastmilk for my infant: ☐ Birth - 5 months ☐ 6 - 11 months

I want the facility to provide the infant formula for my infant: ☐ Birth - 5 months ☐ 6 - 11 months

I will bring the following for my infant: ☐ Birth - 5 months ☐ 6 - 11 months

Please mark your preferences for 6-11 months old _____ **Today's Date**

I want the facility to provide the infant cereal and other foods for my infant: ☐ Yes ☐ No

I will bring the infant cereal and/or other foods for my infant: ☐ Yes ☐ No

Parent Formula Name:_____

I certify that I have received the following: (1) WIC Flyer, (2)"Building for the Future", (3) a Parent Letter, (4) Income Eligibility Guidelines, (5) Income Eligibility Qualifying Form, (6) TDA's Directions on Filling out the Income Eligibility Form, (7) a blank copy of the Child Enrollment Form, (8) CACFP & Civil Rights Complaint Procedures.

Address _____ Phone Number _____

City _____ State _____ Zipcode _____

Parent or Guardian's Name - PRINT _____ Parent or Guardian's Signature _____ Date _____

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have an eligibility number, skip this part.
Part 3: **Applies only to parents/guardians of children in Tier II Day Care Homes**. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.
Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**
Box 2: List the amount each person got from the month from welfare, child support, alimony.
Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is 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: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement:

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, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. 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) eligibility number for the participant or other (FDPIR) identifier 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 if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

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.