



Staff Use Only

Date Received: _____
Received by: _____
Date Processed: _____

Child Care Early Learning Application

Date: _____

☐ Child Care Center (Poulsbo) ☐ Learning Center (Poulsbo) ☐ Early Learning Center (Silverdale)

CHILD/FAMILY INFORMATION

Child's First Name: _____ Last Name: _____
Child Resides With: _____ Gender: _____ Birth Date: _____
Parent/Guardian: _____ Day Phone: _____
Address: _____ Evening Phone: _____
Employer: _____ Other Phone: _____
Parent/Guardian: _____ Day Phone: _____
Address: _____ Evening Phone: _____
Employer: _____ Other Phone: _____
Primary Email for Billing/ Parent Communication: _____
Additional Email (optional): _____
Other Children in Household: _____

AUTHORIZATIONS

(Person listed must be at least 18 years old; ADDRESS REQUIRED)

In case of emergency (if parents cannot be reached), please contact the following who have permission to remove my child from the center:

Name	Full Address	Phone
_____	_____	_____
_____	_____	_____

Other persons permitted to remove my child from the center:

Name	Full Address	Phone
_____	_____	_____
_____	_____	_____

Note: We request notification in advance if someone other than the parent will be removing the child.

Persons RESTRICTED from picking up OR visiting (please attach legal documentation if available):

Name	Full Address	Phone
_____	_____	_____
_____	_____	_____

HEALTH CONTACT INFORMATION

Doctor: _____
Address: _____
Insurance Provider: _____

Phone: _____
City/Zip: _____
Policy #: _____

Dentist: _____
Address: _____
Insurance Provider: _____

Phone: _____
City/Zip: _____
Policy #: _____

HEALTH AND PERSONAL INFORMATION

Date of last physical exam: _____

Date of last dental exam: _____

Is your child on regular medication: ☐ Yes ☐ No

If yes please name medication and dosage: _____

Does your child have any allergies: ☐ Yes* ☐ No

If yes please list: _____

Does your child have any intolerance: ☐ Yes* ☐ No

If yes please list: _____

*If yes, Allergy and Intolerance Health Plan form must be received before start date.

Has the child had the following: ☐ Measles ☐ Mumps ☐ Chickenpox ☐ Whooping Cough
☐ Rheumatic Fever ☐ Scarlet Fever

Does the child have or had any of the following conditions:

	No	Yes		No	Yes
Asthma	☐	☐	Heart Disease	☐	☐
Allergies	☐	☐	Strep Throat	☐	☐
Convulsions, fainting	☐	☐	Serious injury, concussion	☐	☐
Sprains, dislocations, fractures	☐	☐	Ear infections	☐	☐
Operations	☐	☐	Urinary infections	☐	☐
Hospitalizations	☐	☐	Anemia	☐	☐

Other: _____

Does your child need special protection from fatigue or infection: ☐ Yes ☐ No

If yes please list: _____

Can your child have vigorous exercise: ☐ Yes ☐ No

If no please explain: _____

Does your child have any health problems that necessitate special care: ☐ Yes ☐ No

If yes, please explain: _____

HEALTH AND PERSONAL INFORMATION (CONT'D)

Does the child have any vision or hearing problems: ☐ Yes ☐ No

If yes, please explain: _____

Additional health comments/information: _____

_____

_____

_____

PERSONAL HISTORY

Age child began speaking: _____

Does the child speak any other language other than English: _____

If yes, what languages: _____

Does he/she have any unique words or sounds to express wants or needs: _____

_____

_____

Would you describe your child as: ☐ Active ☐ Quiet

What are your child's favorite toys: _____

_____

Methods most effective for dealing with misbehavior: _____

_____

_____

Methods most effective for dealing with positive behavior: _____

_____

_____

SOCIAL HISTORY

Has the child had play experience with other children: ☐ Yes ☐ No Ages: _____

Has the child had previous experience in a childcare setting: ☐ Yes ☐ No

Does the child know other children enrolled in the center: ☐ Yes ☐ No

If so, who: _____

By nature, is the child: ☐ Friendly ☐ Shy ☐ Other: _____

How does the child express anger or frustration: _____

_____

In your opinion, is your child ready for supervised play with others: ☐ Yes ☐ No

EATING/SLEEPING HABITS		
Does the child eat with:	☐ Spoon	☐ Fork ☐ Hands
Does the child feed himself/herself:	☐ Yes	☐ No
General attitude towards eating: _____		
Special likes/dislikes: _____		
General nightly sleep from _____ pm to _____ am		
Typical afternoon nap: ☐ 1 hour ☐ 2 hours ☐ Other: _____		
Mood upon awakening: _____		

TOILETING	
Is child toilet trained:	☐ Yes ☐ No
If yes, at what age:	_____ years _____ months
If no, what assistance does the child need:	_____
Can child indicate toileting wishes:	☐ Yes ☐ No
If yes, how:	_____
Does the child:	☐ Have accidents ☐ Wet the bed at nap ☐ Wet the bed at night
To what degree can the child dress himself/herself:	_____
	_____

[illegible]

PARENT AUTHORIZATION

Walking Trips: I give permission for my child to leave for outdoor exercise, IGP and educational purposes, with the understanding that my child will be accompanied by center staff and under proper supervision at all times.

Transportation: I give permission to Martha and Mary Children's Services to transport my child to and from the site on field trips and other activities. I will be given a specific permission slip for each off-site field trip. Off-site field trips and all transportation of children will meet state child care licensing regulations and center policies including minimum-age requirements.

Medical Emergencies: I give the Martha and Mary staff authorization to administer first aid to my child as necessary. In the event I cannot be reached, I give the Martha and Mary staff permission to obtain medical care for my child. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. I expect that a conscientious effort will be made to locate my designees or myself. I will accept any expenses incurred.

Photographs/Videotape:

_____ I give permission for my child to be photographed and videotaped in the center and during program functions and field trips. I understand that photographs/videos may be taken by center staff or by parents/guardians and may be shared via email to family members.

_____ I give permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting our child care services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation.

Policy: I acknowledge that I have received and understand the Martha & Mary Kids parent information packet and agree to abide by the policies stated therein. I fully understand the rights, responsibilities, and relevant facility policies and procedures. I acknowledge that I understand and agree to abide by the policies of Martha and Mary.

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Office only:

_____ Court documents on file; staff notified of restriction. Date court documents expire: _____
Director Initials & Date

_____ Allergy & Intolerance form received and signed off by physician if required; staff notified and training plan in place.
Director Initials & Date

_____ USDA Medical Disability Statement for Food Substitution(s) received; staff notified and training plan in place.
Director Initials & Date

_____ Health Plan received and signed by physician; staff notified and training plan in place.
Director Initials & Date



Child's Name: _____

Center: _____

☐ New Enrollment   ☐ Updated

Enrollment Agreement Financial Information

CENTER HOURS OF OPERATION

The center is open from 5:30 a.m. to 6:00 p.m., Monday through Friday. Centers will be closed in observance of the following holidays: New Year's Day, President's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, the day after Thanksgiving, and Christmas Day. In addition, centers will close at 4pm on Christmas Eve.

I understand that, in accordance with childcare licensing regulations, my child may be released to the custody of Child Protective Services or other local authorities if I (*or other authorized persons*) fail to pick up my child and/or contact the center and I (*or other authorized persons*) cannot be reached within 30 minutes after close-of-business.

The center will be open whenever possible on regularly scheduled days, during normal business hours. The procedure for notifying families of delays and closures due to inclement weather and/or emergencies will be posted at each center. If it becomes necessary to close early, it will be my responsibility to arrange for my child's prompt pick-up.

FEE SCHEDULE AND FINANCIAL TERMS

1. I agree that, in consideration of admission to Martha & Mary Kids and the rendering of services to my child(ren), I am obligated to pay all charges incurred in accordance with the payment regulations and current rate schedules of Martha & Mary Kids. The rate includes the cost of daily care and all meals for children over the age of one year, except when severe allergies preclude the Center meeting the child's food needs. Certain other charges (including, but not limited to, diapers, field trips, mats, late fees and ten hour fees) will also be billed as appropriate.
2. In addition to the registration fee and mat fee due upon application, an advance payment of 50% of one month's tuition is required. This payment is applied to the first month's charges, and is non-refundable if the child does not attend. A new initial registration fee may be required before enrollment may continue.
3. I understand that a new registration fee will be charged in January each year for any child that has been in attendance for greater than 3 months.
4. Payments are due by the 20th of each month. A late charge is assessed on accounts not paid in full by midnight on the 24th of the month. Accounts not made current by the last day of the month are in default and childcare services will be suspended until the account has been paid in full. I understand that a new registration fee may be required in order for my child(ren) to return. Past due accounts bear interest in the amount of 12% per annum. Should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable attorney's fees and all collection expenses.
5. Martha & Mary will not be responsible for unbalanced ledgers due to parent/guardian disputes. If a bill is paid by more than one party, the division of fees is strictly the responsibility of the parties involved.
6. Tuition fees are not subject to pro-ration for absences, illnesses or emergency closure of the center. I understand that tuition is based on a contracted schedule and that I may add days at the drop-in rate if space is available.
7. I agree that I will pay the full tuition fee, even if my child(ren) is absent for one or more scheduled days. I understand I will receive up to 10 vacation days per calendar year. Vacation day requests must be submitted to the center management and will be charged at a discounted rate of 50%.

Child's Name: _____ Center: _____

8. A late pick up fee will be assessed (per child) when a child attends past close-of-business. I understand that late pick up fees are due on the day of service, and must be paid before my child(ren) returns to care the following day. The late pick up fee does not constitute as agreement to provide after-hours services.
9. A check return fee will be assessed on all returned checks. Payments from customers with prior outstanding redeemed returned checks must be in the form of a money order or cashier's check. Returned check activity may be subject to immediate termination of services.
10. Two weeks' written notice is required prior to the last day of attendance. If I do not give proper notice, I agree to pay any fees or full tuition that may be due for the final two weeks, regardless of my child(ren)'s attendance. I also understand any prepaid funds of \$20.00 or less which remains at the time of my child's disenrollment will not be remitted to me unless requested in writing within 90 days.
11. Where other parties such as state or federal agencies (DSHS) pay a portion or all of the childcare charges, I hereby agree to pay my participation of the charges, or all charges for any period the child is determined to be ineligible for the program, as well as all charges incurred which are properly charged toward the child under such programs. I understand it is my responsibility to ensure that coverage with outside agencies is kept current and up to date. I understand that reauthorization of eligibility must be received from DSHS before the current end date of authorization or enrollment will be terminated. Re-enrollment will not be guaranteed, and will not be considered until such time as proof of eligibility is provided.
12. When seeking to obtain financial assistance through DSHS, I understand that DSHS coverage will be effective as of the date of receipt and that "back-dating" is not accepted, even if authorized by DSHS.

DISCOUNTS AND PAYMENT

Only one discount per family is available. Discounts do not apply to families receiving subsidy. For families with multiple children in our care, the discount is applied to the oldest child's tuition. Discounts are applied to scheduled days only.

Payment Type (select one):

- ☐ Private Pay
- ☐ Employee*
- ☐ DSHS*

*additional forms attached

Discounts (one per family):

- ☐ Sibling Discount
- ☐ Military Discount*
- ☐ CKSD or NKSD Employee Discount

ACKNOWLEDGMENT

I certify that I have read, understand and accept all of the terms and conditions in this Agreement. This Agreement will be effective as of _____, _____ (child's start date OR change effective date).

Parent /Guardian 1 Signature _____ Date _____

Parent / Guardian 2 Signature _____ Date _____

Staff Use Only

Date received: _____

By: _____

Date orientation held: _____

By: _____

Additional forms obtained:

- ☐ DSHS Award Letter
- ☐ Employee Payroll Deduction Authorization
- ☐ DSHS Policies Agreement
- ☐ Military Discount Form

Child's Name: _____ Center: _____

☐ New Enrollment   ☐ Updated Fee Agreement   ☐ Revised Schedule Only

SCHEDULED ATTENDANCE

Tuition fees are based on the following scheduled attendance. I understand I will be charged additional tuition fees if my child's attendance extends beyond the schedule submitted below. I understand I may add days (*if space is available*) at the drop in rate. **If long term schedule changes are needed I understand it must be submitted in writing to the Center Director for authorization by the 15th of the previous month and once approved a new financial agreement with contracted days is required.**

I agree to notify the center staff by 9:00 a.m. if my child will not be in attendance on a scheduled day.

My child will attend on the following days and times:

	Arrival	Departure	Arrival	Departure
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

I understand there is an additional fee for each day that my child is either scheduled for more than 10 hours or is in attendance for more than 10 hours.

☐ I will need care for my child over 10 hours per day due to _____
_____.

AUTHORIZATION

The schedule listed above will effective as of _____, _____ (*child's start date OR change effective date*).

Parent/Guardian 1	Signature	Date

Parent/Guardian 2	Signature	Date

Center Director Signature	Date



Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:

Reviewed by:

Date:

Signed Cert. of Exemption on file? ☐ Yes ☐ No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name:

First Name:

Middle Initial:

Birthdate (MM/DD/YY):

Sex:

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.



Parent/Guardian Signature Required

Date

I certify that the information provided on this form is correct and verifiable.



Parent/Guardian Signature Required

Date

◆ Required for School and Child Care/Preschool

● Required Only for Child Care/Preschool

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Date
MM/DD/YY

Required Vaccines for School or Child Care Entry

◆ **DTaP, DT** (Diphtheria, Tetanus, Pertussis)

◆ **Tdap** (Tetanus, Diphtheria, Pertussis)

◆ **Td** (Tetanus, Diphtheria)

◆ **Hepatitis B**

☐ 2-dose schedule used between ages 11-15

● **Hib** (*Haemophilus influenzae* type b)

◆ **IPV / OPV** (Polio)

◆ **MMR** (Measles, Mumps, Rubella)

● **PCV / PPSV** (Pneumococcal)

◆ **Varicella** (Chickenpox)

☐ History of disease verified by IIS

Recommended Vaccines (Not Required for School or Child Care Entry)

Flu (Influenza)

Hepatitis A

HPV (Human Papillomavirus)

MCV, MPSV (Meningococcal)

MenB (Meningococcal)

Rotavirus

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of **Varicella (Chickenpox)** or can show immunity by blood test (titer) it **MUST** be verified by a healthcare provider

I certify that the child named on this CIS has:

☐ a verified history of Varicella (Chickenpox).

☐ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

☐ Diphtheria

☐ Hepatitis A

☐ Hepatitis B

☐ Hib

☐ Measles

☐ Mumps

☐ Polio

☐ Rubella

☐ Tetanus

☐ Varicella

☐ Other:

Licensed healthcare provider signature
(MD, DO, ND, PA, ARNP)

Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at <https://wa.myir.net>. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements.**

☐ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.

☐ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS.**

Reference guide for vaccine abbreviations in alphabetical order

For updated list, visit <https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf>

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order

For updated list, visit <https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf>

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

Child Care Food Program

Dear Parents:

Our center does not charge separately for meals because it participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). This program pays centers for nutritious meals served to all children while in care.

How much does the center receive in payment for meals served to my child while in care?

The amount of payment received is based on the income status of the families in our center. We receive a higher payment for those families that are low-income.

How do you determine the income status of my family?

The information you provide on the enclosed Enrollment/Income-Eligibility Application determines the income status and payment level.

I'm not sure if my family income qualifies. How do I decide?

If your gross income (before deductions) is the same as or less than the amount on the line for your family size on the income guidelines table below, the center is eligible for the higher payment for your child(ren). When self-employed, net income may be reported. **Please complete the Enrollment/Income Eligibility Application in ink and return it to our office as soon as possible.**

**Income Guidelines
Reduced-Price Meals**

Effective July 1, 2019–June 30, 2020

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	\$23,107	\$1,926	\$963	\$889	\$445
2	\$31,284	\$2,607	\$1,304	\$1,204	\$602
3	\$39,461	\$3,289	\$1,645	\$1,518	\$759
4	\$47,638	\$3,970	\$1,985	\$1,833	\$917
5	\$55,815	\$4,652	\$2,326	\$2,147	\$1,074
6	\$63,992	\$5,333	\$2,667	\$2,462	\$1,231
7	\$72,169	\$6,015	\$3,008	\$2,776	\$1,388
8	\$80,346	\$6,696	\$3,348	\$3,091	\$1,546
For each add'l family member, add:	\$8,177	\$682	\$341	\$315	\$158

If I receive payment from DSHS for child care, should I complete these forms?

Yes. DSHS payments for child care do not qualify a family for the higher payment.

If my household income is greater than the income guidelines for reduced-price meals, or if I choose not to report my income, what should I do?

You should complete Parts 1 and 5 and may write “above-scale” in Part 4.

If I choose not to report my household income, do I still need to return the Enrollment/Income-Eligibility Application?

Yes. If you choose not to fill out the income portion of the Enrollment/Income Eligibility Application (E/IEA), you must still complete Part I, the “Children’s Information” section, and Part 5. Federal regulations require that all child care centers collect information on the normal days and hours child(ren) are expected to be in care and the expected meals to be received.

Is there another way for the center to receive the higher payment other than using my family income?

Yes. Your child(ren) may be eligible for the higher payment based on one of the following:

1. You receive Basic Food, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) for any member of your household.
2. Your child is a foster child.

If a household member currently receives benefits from one of these programs, or I believe my family income would qualify my child, what should I do?

Complete the attached Enrollment/Income-Eligibility Application, following the directions on the form. There is a separate section for each way your child may qualify.

Will this information be kept confidential?

Yes. The information will be made available only to a limited number of our staff or employees of the Office of Superintendent of Public Instruction, U.S. Department of Agriculture, or the U.S. General Accounting Office when they are reviewing our program.

Will the center make menu substitutions for my child?

If your child has been determined by a doctor to be disabled, and the disability would prevent the child from eating the regular meals at the center, we will make any substitutions prescribed by the doctor at no extra charge.

What do I need to bring to the center if my child needs menu substitutions?

You must bring the doctor’s note that prescribes the alternative foods needed and verifies special meals are needed due to the disability.

Whom should I contact if I have any questions?

Contact your center’s main office at:

Child Care Center (CCC)	360-394-4093
Children’s Learning Center (CLC)	360-394-4085
Early Learning Center (ELC)	360-626-2131

Thank you for helping us provide healthy meals for your child.

Sincerely,

Your Center Directors (Haley K., Jessica P. & Era A.)

In the operation of the child feeding programs, no child will be discriminated against because of race, color, national origin, sex, age, or disability.

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.															
List names (First and Last) of everyone in your household, including foster children	Tell us how much and how often. If no income, write "0". Use net income if self-employed.														
	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. <i>See Privacy Act Statement on the back of this page.</i> 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 X _____	Today’s Date _____	Print Name of Adult Signing _____ 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.