America's Best/Another Best Childcare & Learning Center Inc. Enrollment Agreement

414Child's Information

Registration Paid	Start Date	Last Date Attended

Child's first name	Child's middle name	Child's last name	Child's nickname

Birth date	Age	Gender	Parent/guardian/sponsor primary language	Child's primary language

Child's home address	City	State	Zip

Family Information

With Whom does the child live
:☐ Both Parents ☐ Mother ☐ Father ☐ Other

If Parents are separated, single or divorced, who has legal custody ☐ Both Parents ☐ Father ☐ Mother

If there is a court valid no-contact order in place?
☐ No ☐ Yes – A valid copy of No Contact must be provided to center staff.

List names and relation (include age of siblings) of all persons living in the home

Parent/guardian/sponsor	Relationship to child	Home phone	Cell phone

Home address if different from above	City	State	Zip

Home email	Work email	Work phone

Employer	Employer address	City	State	Zip	Work hours

Other parent/guardian/sponsor	Relationship to child	Home phone	Cell phone

Home address if different from above	City	State	Zip

Home email	Work email	Work phone

Employer	Employer address	City	State	Zip	Work hours

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day. For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up. The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Person #1	Relationship to child	Home phone	Cell phone

Home address	City	State	Zip

Home email	Work email	Work Phone

Person #2	Relationship to child	Home phone	Cell phone

Home address	City	State	Zip

Home email	Work email	Work Phone

Person #3	Relationship to child	Home phone	Cell phone

Home address	City	State	Zip

Home email	Work email	Work Phone

Completion of this entire agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations. Submittal of this agreement authorizes America's Best/Another Best Childcare and Learning Center Inc. to provide care for your child. You certify that the information provided in this agreement is correct to the best of your knowledge

Parent Signature_________________________________ Date ____________________

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Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color

Distinguishing marks

Child's Medical & Developmental History

1. Does your child have any special medical conditions? □ No □ Yes Explain
2. Does your child have any chronic illnesses? □ No □ Yes Explain
3. Please list a brief history of your child's serious injuries and hospitalizations.
4. Does your child have diabetes? □ No □ Yes - *If yes, please attach health plan / care instructions from your physician.*
5. Does your child have asthma? □ No □ Yes - *If yes, please attach health plan / care instructions from your physician.*
6. Will medication be administered regularly? □ No □ Yes - *If yes, please complete supplemental medication permission form*
7. Does your child have any special dietary needs? □ No □ Yes - Explain
8. Is your child able to fully participate in all activities? □ Yes □ No: Explain
9. Does your child have any physical restrictions? □ No □ Yes: Explain
10. Does your child function at the level of other children in his/her age group? □ Yes □ No: Explain
11. Is your child able to walk □ Yes □ No
12. Can your child communicate his/her needs? □ Yes □ No
13. Does your child need assistance at meal time? □ No □ Yes Explain
14. Is your child toilet trained? □ No □ Yes
15. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? □ No □ Yes: Explain
16. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? □ No □ Yes: Explain
17. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting?
    □ No □ Yes: Explain

Illness History *(please check all that apply)*

Other Known Health Issues:

- □ Vision problems
- □ Hearing problems
- □ Constipation
- □ Diarrhea
- □ Asthma/Respirtory
- □ Nosebleeds
- □ Skin rashes
- □ Sore throats
- □ Ear infections
- □ Urinary tract infections
- □ Seizures
- □ Mouth sores
- □ Fainting
- □ Persistent cough
- □ Other

Disease History *(please check all that apply and add the date)*

- □ Chicken Pox (Varicella)
- □ Measles Rubeola
- □ Rubella (German Measles)
- □ Mumps
- □ Scarlet Fever
- □ Bronchiolitis
- □ Pneumonia
- □ Pertussis (Whooping cough)
- □ Tetanus
- □ Diphtheria
- □ Botulism
- □ Haemophilus Influenza
- □ Meningococcal Infection
- □ Rabies
- □ Bacterial Meningitis

↓ KNOWN ALLERGIES

Medication Allergies	Reaction	**Food** Allergies	Reaction
Bee Stings Allergies	Reaction	**Respiratory** Allergies	Reaction
Other Allergies	Reaction	**Are any of these allergies life-threatening?**	□ **Yes** □ **No**

If Allergies Are Present Please Complete Supplemental Allergy and Anaphylaxis Emergency Plan || If Food Allergies/Intolerance Are Present Please Complete Supplemental Food Allergy/Intolerance Care Plan

Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

- □ Vision
- □ Hearing
- □ Speech
- □ Developmental
- □ Aptitude
- □ Educational
- □ Tuberculosis (PPD)
- □ Sickle Cell Anemia
- □ Other

Parent Signature________________________________ Date ___________________

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Medical Information (continued)

Child's name	Birth date

Child's Medical Care Provider

Primary physician's name	Date of Last Medical Exam	Phone

Physician's practice address	City	State	Zip

Preferred hospital/clinic for emergency care	City	State

Dentist's name	Date of Last Dental Exam	Phone

Dentist's practice address	City	State	Zip

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number

Additional Medical Policies

Initial

1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations. ________
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs. ________
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious. ________
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than ½ hour after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release* section. ________

Emergency Medical Authorization & Consent

REQUIRED FOR ENROLLMENT AND ATTENDANCE

Initial

I hereby give permission that my child (print full name) ____
may be given emergency treatment by a qualified staff member at America's Best/Another Best Childcare and Learning Center Inc. ________

In case of a medical emergency, the staff will attempt to contact me followed by those listed in the *Child Emergency Contact and Release.* ________

When I cannot be contacted, I authorize and consent to medical, dental, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital, or aid car attendant, when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment. ________

In case of a medical emergency, I agree that my child may receive first aid and/or CPR. ________

In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel. ________

In case of a medical emergency, I will be responsible for the emergency medical expenses. ________

In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center. ________

Parent Signature ____ Date_________________

Disaster Awareness / Out Of Area Contact: 100+ Miles Away

Our Crisis/Disaster Response Handbook is available for you to review. During a disaster, communication may become challenging. Often it is easier to contact an out-of-area phone number rather than a local or cell number.

Our out-of-area contact is: Sheryl 406-261-7630

Please provide an out of area contact (100+miles away).

Name	Relationship to child	Home phone	Cell phone

Parent Signature________________________________ Date ___________________

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Other Agreements

Photo Release

I understand that photos will be taken of my child and displayed within the center. This assists with a sense of belonging, provides and aid for name recognition, and helps the child identify and/or initiate conversations regarding peers. **Initial** __________

Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website and/or Facebook.
Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.
If you "LIKE" the center's Facebook page, you will receive a one-time credit of $10. **Initial**__________

Dental Hygiene Activity Requirements - *WAC 110-300-0180*

Child's name	Birth date

Washington State requires that licensed childcare providers offer tooth-brushing activities to children each day. Our goal will be to include developmentally appropriate daily oral health activities in a variety of forms: books, brushing model teeth, songs, and discussing healthy eating habits. Washington State has implied that childcare centers try to participate in actual tooth brushing. As the parent/guardian, you can opt in or opt out of actual tooth brushing.

☐ I OPT OUT OF actual TOOTH BRUSHING at America's Best &/or Another Best Childcare.

- All Tooth brushing activities occur at home

☐ I OPT IN

If you would like to opt in, ABC requires the following:

- A single use disposable toothbrush and a single use disposable cup must be brought in each day as there will be no storage of toothbrushes on site, and all used toothbrushes/cups must be disposed of immediately.
- Failure to bring a disposable toothbrush or disposable cup daily will result in a $10 per occurrence fee.
- The tooth brushing will only be performed upon arrival at the center, with the parent/guardian present, near a designated waste receptacle. The cup (for spitting) and toothbrush will be disposed immediately following tooth brushing, to prevent cross contamination. Activity will occur without use of toothpaste.

Parent Signature	Date

NOTE: Age Appropriate Oral health activities will be implemented regardless of opting in or out of actual brushing.

Acknowledgementss

	Initial
I understand that it is my responsibility to go directly to management with any questions I may have regarding center policies and procedures, family handbook, and information contained in this Enrollment Agreement.	________
I understand and agree that it is my responsibility to read and familiarize myself with all content outlined in the Family Handbook and I agree to abide.	________
I understand that information contained in the Family Handbook may be subject to change.	________
I understand and agree that it is my responsibility to read and familiarize myself with operational policies/plans concerning health care, emergency/disaster, and pesticide use. I acknowledge that I have been made aware of these plans/policies. I understand that they're available for review, on-site, at my convenience.	________
I understand the importance of developmental screenings for each child from birth through age five. I understand that the center has and will share information about organizations that conduct developmental screenings such as a local business, school district, health care provider, specialist, or resources listed on the DCYF web site.	________
I agree to adhere to any policies regarding actions I may need to take in the event of emergency/disaster occurrences.	________

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Parent Signature________________________________ Date ___________________

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Contract/Agreement Awareness Verification

The Family Handbook, the enrollment agreement, and operational policies/procedure plans outline the responsibilities of both the provider and the parent/guardian.

Please be familiar with provisions set forth in the enrollment agreement, the Family Handbook, and operational policies/procedure plans – including the Emergency/Disaster plan, Health Care Plan, Pesticide Plan.

The laws of the state of Washington make this contract/agreement a legal and binding document.

I/We certify that the information that provided in this enrollment agreement is true to the best of my/our knowledge.

I/We, the undersigned authorize America’s Best/Another Best Childcare and Learning Center Inc.
to provide care for my/our child:

Child Name	Birth date

I/We, the undersigned, being fully aware and understanding completely, the regulations and responsibilities set forth in this contract, do by virtue of my/our signature(s), agree to abide by, and fulfill, all responsibilities, and regulations, understanding that failure to do so will result in the termination of care and/or legal action.

Parent/Guardian Signature & Date	Parent/Guardian Signature & Date	Provider Signature & Date

Parent Signature________________________________ Date ___________________

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Rate Agreement and Contract

Child's name	Birth date

Regular operating days are **Monday thru Friday,** except closings for various holidays, staff training, and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures.

Scheduled/Contracted Attendance

The days and hours that I wish to contract for childcare are as follows:

Day of week	Drop Off Time	AM/PM	Pick-Up Time	AM/PM
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

Your child is contracted for the _____ days weekly, as listed.
They cannot be changed or traded.
You may add extra days, with preapproval from the director,

at your daily rate of $______________.

Initial __________ Date____________________

As a private -pay in advance- client please initial and complete the payment plan of your choosing below

□ *MONTHLY* _______	□ *BI-WEEKLY*_______	□ *WEEKLY* _______
PLAN ! – Private Payment:	PLAN 2 – Private Payment:	PLAN 3 – Private Payment:
Advance payment is due by the LAST FRIDAY MORNING of every month, for the next month's childcare.	Advance Bi-Weekly Payment is due by **10AM, every other Friday** morning.	Advance weekly payment is due by **10AM, every Friday morning**.
5% discount for month in advance – if on time. Refer to page 14 of Family Handbook, for computation.		
Based on Daily Rate of $________	$____________ Due Bi-Weekly	$____________ Due Weekly

As a subsidy sponsored client please

_______ initial and complete the plan below.

PLAN 4 – Subsidy 3rd Party
Advance verification of coverage is required prior to attendance.
All co—payments are due, from the parent/guardian, by the last Friday of the month for the next month of childcare.
Payments are past due on the 5th, late fee of $15. is added, and child may not attend until account is paid.

$__________ Monthly Co-Payment

If the 3rd party fails to make payment, parent/guardian is immediately responsible for balance owing.

Fee Policy

	INITIAL
I understand I must call in by 10:00AM and notify the center if my child will be arriving late. I understand my child is considered absent at 10AM and will not be able to attend that day if I failed to phone the center by 10AM.	_________
A late payment fee of $15.00 is due, per week, if tuition or copayment is not received on time – 10AM on scheduled Friday.	_________
Tuition pays for enrollment, not attendance - there is no refund, credit, or reduction in tuition costs for absences, vacations, snow days, illnesses, professional training closure, holidays or other instances that a child is not in attendance during regularly scheduled days/times.	_________
A non-refundable registration fee of $75 is due at registration and every fall, by September 1st.	_________
I understand that I am to provide a blanket and sheet daily for my child. If I do not provide one there will be a $10 weekly laundry fee for use of center supply. I understand if I "OPT IN" for tooth brushing and fail to bring supplies, there is a $10 per occurrence fee.	_________
A late pick up fee of $20 per child, for the first 15 minutes, and $5 per child, per additional 15-minute portions is due if my child is not picked up before closing.	_________
If time child is in care exceeds 10 hours daily, I understand I will be responsible for overage, at the rate of $20.00 per hour.	_________
There is a $150 per school year fee for transportation/bus supervision, due September 1st or on first service day, this is not pro-rated.	_________
There will be a $10 fee for the first notice from the bank of NSF funds. There will be a $50 charge for all returned checks in addition to any other charges made by the bank. Cash or Cashier's Check will be required as payment for returned checks. Your account will be placed on cash only status after two returned checks.	_________
I understand that payments made by clients go to UNPAID FEES BEFORE applying to balance of care or co-payment.	_________
A two-week written notice is required for any child being withdrawn from the program. Payment is due regardless of attendance.	_________
Financial statements will be provided UPON REQUEST for the current year. Any additional years will be charged a rate of $50 per hour.	_________

Parent Signature________________________________ Date ___________________

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Certificate of Immunization Status (CIS)

Reviewed by:	Date:
Signed COE on File? ☐ Yes ☐ No	

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

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate (MM/DD/YYYY):**

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X ________ **Parent/Guardian Signature** **Date**	X ________ **Parent/Guardian Signature Required if Starting in Conditional Status** **Date**

▲Required for School ●Required Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (*Haemophilus influenzae type b*)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ 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)						
COVID-19						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐Polio (all 3 serotypes must show immunity)

►

Licensed Health Care Provider Signature Date

►

Printed Name

I certify that the information provided on this form is correct and verifiable.	Health Care Provider or School Official Name: ________ Signature: ________ Date:________ If verified by school or child care staff the medical immunization records must be attached to this document.

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

To print with the immunization information filled in:
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). 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: waiisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:
1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. 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 Guides 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. 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 health care 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. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:
- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status
Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

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 (PV5)
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 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. *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 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, 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:

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

FAX: (833) 256-1665 or (202) 690-7442; or
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.