



Denton City County Day School
- est. 1952 -

Enrollment Packet

1603 Paisley, Denton, Texas 76209
940-382-6485
940-381-2418 fax
dccds@verizon.net

Checklist

- **Completed Enrollment Forms with Signatures-all pages must be completely filled out**
- **Immunization and Doctors Health Statement**
- **Income Verification (copy of two current paystubs or yearly tax forms for Food Program Eligibility)**
- **Non-refundable Enrollment Fee- \$75.00 (money order)**

Partners



Denton City County Day School (DCCDS) Enrollment Information

Child's Name: _____ (Male/Female) Nickname: _____

Date of Birth: ___/___/___ Date of Admission: _____ Date of Withdrawal: _____

Mother's Name: _____ **Father's Name:** _____

Address: _____ Address: _____ Zip _____

City/State _____ Zip _____ City/State _____ Zip _____

| | |
|---|--|
| Do you reside in the city limits of Denton? <input type="checkbox"/> Yes <input type="checkbox"/> NO | How many years have you lived in Denton city or county? |
|---|--|

Mom's place of employment _____ Dad's place of employment _____

Mom's Main Phone _____ Dad's Main Phone _____

Mom's Work Phone _____ Dad's Work Phone _____

Mom's E-mail address _____ Dad's E-mail address _____

Or if child is with a legal guardian, complete: **Guardian Name:** _____

Address: _____ City/State: _____ Zip _____

Guardian place of employment _____ Guardian Main Phone _____

Guardian Work Phone _____ Guardian E-mail address _____

| | | | |
|--|------------------------------|---|---|
| Child's Ethnicity: <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non-Hispanic/Latino | Child's Race: specify | Primary/Native Language: | Child Lives With: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Guardian |
| Is this a single parent household? <input type="checkbox"/> Mother <input type="checkbox"/> Father | | Is anyone in the home disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Parent/Guardian Education: <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> Associates <input type="checkbox"/> Bachelors <input type="checkbox"/> Masters + | | | |

My child will or will not be attending Ann Windle school from Aug-May.

My child will normally be in care the following days and times:

| Circle the Days of attendance | From: (time) | To: (time) |
|-------------------------------|--------------|------------|
| Monday | am | pm |
| Tuesday | am | pm |
| Wednesday | am | pm |
| Thursday | am | pm |
| Friday | am | pm |

I understand the following meals will be served to my child while in care: Breakfast (if arrive before 8:35am)
 Lunch Afternoon Snack

Parent Signature _____ Date: _____

Child's Name: _____

List siblings and ages _____

What is the primary language your child speaks at home? _____

What is the **primary language you speak at home?** _____

Is your child potty-trained? (**Children enrolling in three's and four's MUST BE potty-trained**) Yes No In Process

What experiences has your child had away from parents? How does your child react away from parents? _____

How does your child react away from parents? _____

Does your child have any special fears? _____

How does your child communicate his/her needs? _____

When your child gets upset, what helps him/her calm down? _____

Has your child attended a preschool or daycare before? If so describe your child's behavior at school? _____

Has your family or child been disenrolled from a previous childcare center or school? Yes No Describe the circumstances that led to this dismissal: _____

How do you tell your child to stop a behavior that you don't approve of or that might be unsafe? _____

What are your child's interests? _____

List pets and family hobbies _____

Are there special circumstances in your family we should be aware of? (Custody information, divorce, restraining orders, etc.) We must have a copy of all legal documents on file in order to enforce them. All information will be kept confidential.

Child's Name: _____

Authorized Pick Up List

I hereby authorize DCCDS to allow my child to leave the school **ONLY** with the following persons. Please list the name, phone number and driver's license number of all persons (**18 years of age and older**) who have my permission to pick up my child at school. **Only persons with names on this list will be allowed to pick-up my child from DCCDS.**

In the event a person not listed has to pick up my child, I understand that the school office must receive a phone call or email from one of the approved parents stating the person's name and driver's license number. Names may be added or removed from this list at any time. **Parent's names and driver's license number must be included.**

Name: _____ Phone: _____

DOB: _____ State & Driver's License# _____ Relationship to child: _____

Name: _____ Phone: _____

DOB: _____ State & Driver's License# _____ Relationship to child: _____

Name: _____ Phone: _____

DOB: _____ State & Driver's License# _____ Relationship to child: _____

Name: _____ Phone: _____

DOB: _____ State & Driver's License# _____ Relationship to child: _____

Name: _____ Phone: _____

DOB: _____ State & Driver's License# _____ Relationship to child: _____

Signature of Parent or Legal Guardian

Date

Emergency Contacts

In case you (the parent) cannot be reached, you must give three names, telephone numbers and address of people that can pick up your child:

| | | |
|------|-----------|---------|
| Name | Telephone | Address |
|------|-----------|---------|

| | | |
|------|-----------|---------|
| Name | Telephone | Address |
|------|-----------|---------|

| | | |
|------|-----------|---------|
| Name | Telephone | Address |
|------|-----------|---------|

Child's Name: _____

Does your child have any food, medication or environmental allergies? No Yes (check all that apply)
Food Medication Environmental List allergies: _____

How should we respond if he/she has an allergic reaction? _____

Allergy Plans must be on file for all children with diagnosed allergies. A physician's note including listed allergy (ies), signs and symptoms and treatments must be included in the plan.

Does your child have a special health or medical condition, previous serious illness or injuries and hospitalizations within the past 12 months? No Yes - please explain _____

Does your child have emotional, behavioral or physical needs? (Speech, hearing loss, learning disability, or other special diagnosis) No Yes – please explain _____

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? No Yes – please explain _____

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?
No Yes – **If your child has special dietary needs, as prescribed medically, and not able to have the food provided by the school, parents will be responsible to send prescribed nutritional food for their child.**

Is your child taking any medication? No Yes-if so, how is the medication administered, and will it need to be administered while in school? _____

Any medication must have the medication form filled out by the parent, be in original container containing prescription label with the child's name clearly marked. We ARE NOT able to give a child NON-Prescribed medication, Tylenol, Motrin or Advil.

Health Statement

ADMISSION REQUIREMENT: To attend DCCDS, one of the following must be presented BEFORE your child is admitted to the school:

1. **HEALTH-CARE'S PROFESSIONAL STATEMENT: I have examined the above-named child within the past year and has been found free of contagious disease and may participate in all school activities.**

Health Care Professional's Signature

Date

2. **A signed and dated copy of a health care professionals' statement is attached.**

3. **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 dated and signed affidavit stating this.**

Sight and hearing screenings: For children age 4 years old

| | | | |
|-----------------|----------------|----------------|---|
| VISION | R 20/ _____ | L 20/ _____ | <input type="checkbox"/> PASS <input type="checkbox"/> FAIL |
| SIGNATURE _____ | | DATE _____ | |
| HEARING | 1000 Hz | 2000 Hz | 4000 Hz |
| R | | | |
| L | | | |
| SIGNATURE _____ | | DATE _____ | |

A copy of the child's current shot record must be attached to this form. Up-to-date immunizations are required by state licensing to attend Denton City County Day School.

Child's Name: _____

Authorization for Emergency Medical Attention:

In the event of a medical emergency and a parent cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

| | | |
|----------------------------------|----------|---------|
| Name of Doctor: | Address: | Phone#: |
| _____ | _____ | _____ |
| Name of Emergency Care Facility: | Address | Phone# |
| _____ | _____ | _____ |

Insurance Company: _____ Policy #: _____

I give my consent for necessary emergency treatment when my child is in the care of this physician and/or hospital.

Signature of Parent or Legal Guardian

CONSENT TO ADMINISTER EMERGENCY SERVICES

It is the responsibility of Denton City County Day School to issue the following statement as part of the school's policy: In case of emergency, Denton City County Day School (DCCDS) will act as parent or guardian of each child while he/she is under the care of DCCDS. This means that DCCDS staff will, in good faith, act in the child's best interest by notifying emergency services of a serious or life-threatening condition. Notification of emergency services will result only if DCCDS staff, in their sole discretion, judge that the child's health or well-being is threatened for any reason.

Your signature below shall act to indemnify and hold DCCDS harmless from any claims that arise out of the use of this authorization and will act to authorize DCCDS to take such action as it deems necessary, in its sole discretion, to protect your child in the case of a serious or life-threatening condition. Further, DCCDS is not assuming liability for any fees or charges that result from such action, including emergency room bills, emergency transport bills, or hospital or doctors' fees. All such fees shall continue to be the responsibility of the parent and parent shall indemnify DCCDS for any such fees.

I, agree to the terms of the above school policy. In signing, I agree to allow Denton City County Day School to act as parent or guardian of my child in case of emergency.

Signature of Parent or Guardian

Date

Child's Name: _____

Photography, Videos & Social Media:

I (we) hereby grant to Denton City County Day School permission to take and use photographs or videos of my child. I (we) also grant to Denton City Day School permission to use the finished photographs or videos for the purpose of education and/or membership promotion, including social media, i.e. Facebook and website, and grant the right to publish and/or publicly exhibit the photographs or videos in any lawful and legitimate manner.

Signature of parent or guardian

Date

Water Play : (please initial on the line provided)

_____ I understand that during the summer months that DCCDS may have water/sprinkler play/ with adult supervision. My child will take part of this activity

OR

_____ During water play my child will sit outside and play. We do not have alternative staff to keep children inside during this time frame. All children will be outside. If you choose not to be part of water play, children will be given chalk or bubbles.

Signature of Parent or Legal Guardian

Date

RECEIPT OF WRITTEN OPERATIONAL POLICIES: (parent handbook is online for review)

I acknowledge receipt of the Denton City County Day School (DCCDS) operational policies in the parent handbook, including those for:

Discipline and Guidance

Procedures for release of children

Suspension and expulsion

Illness and exclusion criteria

Emergency plans

Procedures for dispensing medication

Procedures for conducting health checks

Immunization requirements for children

Meals and Food Service practice

Food Allergy Plans

Procedures for parents to discuss concerns with the director

Procedures to visit the center without securing prior approval

Procedure for parents to participate in operation activities

Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline and DFPS website

Signature of Parent or Legal Guardian

Date



**City of Denton Community Development
SELF-CERTIFICATION INCOME FORM**

This program is made possible through the support of the **City of Denton Community Development Block Grant (CDBG)** program. CDBG is a federally funded program through the U.S. Department of Housing and Urban Development (HUD), administered by City of Denton and designed to serve low- and moderate-income individuals. To meet the program national objectives, this data needs to be collected and reported to HUD through the City of Denton. This form is utilized as data and is required to ensure compliance with rules and regulations for the use of these funds.

Directions: Please **CIRCLE** your family size and yearly income level below. Provide your signature and date below

| Qualifying Income Limits for Federally Assisted Programs | | | | |
|---|----------------------------------|-----------------------------|----------------------------------|-----------------------------------|
| Maximum Income Levels | | | | |
| Family Size | Moderate Income 80% - 65% AMI | Low Income 65% - 50% AMI | Very-Low Income 50% - 30% AMI | Extremely-Low Income ≤ 30% AMI |
| 1 | \$46,550 - \$37,850 | \$37,850 - \$29,100 | \$29,100 - \$17,500 | \$17,500 - or below |
| 2 | \$53,200 - \$43,250 | \$43,250 - \$33,250 | \$33,250 - \$20,000 | \$20,000 - or below |
| 3 | \$59,850 - \$48,650 | \$48,650 - \$37,400 | \$37,400 - \$22,500 | \$22,500 - or below |
| 4 | \$66,500 - \$54,000 | \$54,000 - \$41,550 | \$41,550 - \$25,750 | \$25,750 - or below |
| 5 | \$71,850 - \$58,350 | \$58,350 - \$44,900 | \$44,900 - \$30,170 | \$30,170 - or below |
| 6 | \$77,150 - \$62,700 | \$62,700 - \$48,200 | \$48,200 - \$34,590 | \$34,590 - or below |
| 7 | \$82,500 - \$67,000 | \$67,000 - \$51,550 | \$51,550 - \$39,010 | \$39,010 - or below |
| 8 | \$87,800 - \$71,300 | \$71,300 - \$54,850 | \$54,850 - \$43,430 | \$43,430 - or below |

Source: U. S. Department of Housing and Urban Development - Effective: 04/2019

CERTIFICATION: I certify that I am a resident of the city of Denton and that my family size and annual income level selected above is correct and accurate to the best of my knowledge. I am aware that I may be asked to provide additional documentation to confirm my selections.

PRINT NAME DATE

SIGNATURE DATE

Circle Your Family Size & Income Above

| | |
|--------------------|---------------------|
| office use only: | |
| REVIEWED BY STAFF: | Attach Verification |
| _____ Signature | _____ DATE |



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We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) Denton City County Day School to initiate credit card charges to the below-referenced credit card account (**Section A**) OR, initiate debit entries to my (our) checking or savings account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

| | | | |
|----------------------|--|-----------------|-----------|
| _____ | | _____ | |
| Cardholder Name | | Phone # | |
| _____ | | _____ | _____ |
| Cardholder Address | | City | State Zip |
| _____ | | _____ | |
| Account Number | | Expiration Date | |
| _____ | | _____ | |
| Cardholder Signature | | Date | |

SECTION B (Bank Account)

| | | | |
|---|-----------------------------------|-----------------------------------|----------------------------------|
| _____ | | _____ | |
| Your Name | | Phone # | |
| _____ | | _____ | _____ |
| Address | | City | State Zip |
| _____ | | _____ | |
| Bank or Credit Union Name | Bank or Credit Union Address | City | State Zip |
| _____ | | _____ | |
| Routing Transit Number (see sample below) | Account Number (see sample below) | <input type="checkbox"/> Checking | <input type="checkbox"/> Savings |
| _____ | | _____ | |
| Authorized Signature | | Date | |

For Official Use Only

| |
|--------------------|
| Date Received |
| |
| Employee Signature |
| |



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Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Denton City County Day School** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [(Name of Center, address, phone number)].**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Income Chart, sent with this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. (Pricing program only) Will the information I give be verified? Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You can talk to the **Director** either in person or by telephone at **940-382-6485**. You may ask for a hearing by calling or writing to: **1603 Paisley, Denton, Texas 76209**

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

If you have other questions or need help, call **940-382-6485**.

Denton City County Day School
1603 Paisley
Denton, Texas 76209
940-382-6485

Nondiscrimination statement and complaint Filing Procedures

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

Denton City County Day School operation meets the Americans with Disabilities Act (ADA), Title III. If you believe that DCCDS 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.

**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 case number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits.

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 a case 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 |
| | <input type="checkbox"/> | | | <input type="checkbox"/> |
| | <input type="checkbox"/> | | | <input type="checkbox"/> |
| | <input type="checkbox"/> | | | <input type="checkbox"/> |
| | <input type="checkbox"/> | | | <input type="checkbox"/> |
| | <input type="checkbox"/> | | | <input type="checkbox"/> |
| | <input type="checkbox"/> | | | <input type="checkbox"/> |
| Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3. NAME: _____ CASE 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 <i>List of Eligible Federal/State Funded Programs (H1660)</i> , provide the name of the program and case number: NAME: _____ CASE NUMBER: _____ Check here if no case number <input type="checkbox"/> | | | | |
| Part 4. Total Household Gross Income—You must tell us how much and how often | | | | |
| A. Name (List only household members with income) <i>(Example)</i> Jane Smith | 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 |
| | \$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>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.</i> Sign here: _____ Print name: _____ Date: _____ Address: _____ Phone Number: _____ City: _____ State: _____ Zip Code: _____ Social Security Number: ___ - ___ - _____ <input type="checkbox"/> 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: | |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| | <input type="checkbox"/> 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) case 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, 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.