Amazing Kidz Academy LLC
"Early Learning Child Care & After School Program"

Site 1: 1267 E. Cheltenham Avenue, Philadelphia, PA 19124 – 215-535-5439	Site 3: 7120 N. Broad Street, Philadelphia, PA 19126 - 215-224-8000
Site 2: 700 East Erie Avenue, Philadelphia, PA 19134 - 215 423-1000	Site 4: 4719 Rising Sun Avenue, Philadelphia, PA 19120 - 215-324-6000

www.amazingkidz123.com

www.amazingkidz123.com

Preschool Application

for Academic Year

2022 - 2023

Monday – Friday 8:00 am until 2:00 pm

Wrap around care available with private pay or ELRC subsidy

FREE HIGH QUALITY PreKindergarten!

REASONS TO CHOOSE OUR CENTER

- *Nutritious meals via CACFP Program*
- *High quality programs*
- *Bright beautiful centers*

Thank you for your interest in **Amazing Kidz Academy LLC's** a preschool program! We are excited to be able to partner with you in your child's early learning experience. Please complete all necessary steps below and provide supporting documentation. As you collect each item, check off the box. Applications missing supporting documentation below may be considered incomplete which may delay the enrollment process.

- ☐ **I have filled out the entire application**
- ☐ **I have proof of child's or children's date of birth (***birth certificate, health insurance card, etc***.)**
- ☐ **I have documentation of family income (***tax forms, 4 consecutive paystubs, or financial support letter***) PreK Counts Only**
- ☐ **I have proof of Philadelphia residency (***bill, driver's license, lease, etc.)* **PHLpreK Only**
- ☐ **I have my child's or children's health insurance card**
- ☐ **I have my child's or children's completed yearly well-child visit form which includes immunizations**
- ☐ **I have proof of child's or children's dental visit**
- ☐ **I have picture identification of parent/guardian (Any photo id with primary guardian's Name)**
- ☐ **I have proof of TANF (DPW) cash, SNAP/food stamps, medical assistance (if applicable)**
- ☐ **I have a custody order (***if this applicable***)**
- ☐ **I have a foster letter (***if this applicable***)**
- ☐ **I have a homeless verification letter/shelter letter (***if applicable***)**

** Both the dental and yearly well-child visit forms must be dated within a year at the time of enrollment. Enrollment may be delayed if these forms are not up to date at time of placement.*

PRIMARY PARENT
The adult who is primarily responsible for the care and well-being of the child.

First Name:		**Last Name:**	
Date of Birth:		**Gender:** ☐ **Male** ☐ **Female**	
Primary language:		**Other language(s):**	
Home Address:			
Apt./Unit#:	**City:**	**State:**	**Zip Code:**
Phone#:	**Email Address:**		
# of People in household		**# of People in Family**	
Marital Status Select one	Married ☐	Single ☐	Widowed ☐ / Separated/Divorced ☐
Relationship to Child select one	Parent/Stepparent ☐	Grandparent ☐	
	Foster/Kinship Parent, related to child ☐	Foster Parent, not related to child ☐	
	Guardian, related to child ☐	Guardian, not related to child ☐	
	Other (specify):	Teen Parent, parent was under the age of 18 when child was born ☐	
Race/Ethnicity Select all that apply	Hispanic or Latina ☐	American Indian ☐	Asian ☐
	Black or African American	Multi or Bi Racial ☐	Native Hawaiian ☐
	Pacific Islander ☐	White ☐	Other (specify):
Education Select highest Diploma/Degree earned or Highest grade level completed	High School Diploma ☐	GED ☐	ESL – English as a second language ☐
	Some college/Vocational/Associates	Bachelors/Advanced degree	
	11th Grade ☐	10th Grade ☐	9th Grade ☐
Employment, School, Job Training (select all that apply)	Employed/Self Employed ☐	Unemployment/Not Employed ☐	Disabled ☐
	U.S. Military on Active Duty ☐	Veteran of the U.S. Military ☐	

Do you have health insurance? ☐ Yes ☐ No If yes, who is the provider? (please write below)

Do you receive ELRC? ☐ Yes ☐ No | Will you need any private pay services? ☐ Yes ☐ No

Which program are you applying for↓

☐ PHLpreK	☐ PreK Counts	☐ ELRC Child Care	☐ Wrap Around	☐ Before & After Care

EMERGENCY CONTACT/PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270 124(a)(b), 3270 181 & 182, 3280 124 (a)(b) 3280 181 & 182

Child's First Name:	**Child's Last Name:**
Date of Birth:	**Gender:** ☐ **Male** ☐ **Female**
Address:	
Parent's Name:	

LOCATIONS

Choose the location you would like: ☐ **Cheltenham** ☐ **Broad Street** ☐ **Erie** ☐ **Rising Sun**

Enrollment Date:	**Start Date:**	**Withdraw Date:**

Emergency Contact Person(s)	**NAME**	**ADDRESS**	**TELEPHONE NUMBER WHEN CHILD IS IN CARE**

PERSON(S) TO WHOM CHILD MAY BE RELEASED	**NAME**	**ADDRESS**	**TELEPHONE NUMBER WHEN CHILD IS IN CARE**

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REATION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST – AID PROCEDURES**
WALKS AND TRIPS	**SWIMMING**
TRANSPORATION BY THE FACILITY	**WADING**

_____ _____

SIGNATURE OF PARENT or Guardian — Date

_____ _____

SIGNATURE OF PARENT or Guardian — Date

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(C); 3280.123 & 181(C); 3290.123 & 181(C)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK Weekly	DAY PAYMENT TO BE MADE Every Friday

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

Quality Childcare with HighScope and Creative Curriculum

Breakfast, Lunch, and Snack is provided

School Age Pickup and Drop-off for K-12 years old

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $1.00	PER MIN-HR minute	

Extra services to be provided at an additional fee if applicable

Field trips will be provided during the course of the school year.

Professional seasonal photography for school pictures

I, the parent/guardian;

[X] received complete written program information at the time of enrollment (3270.121, 3280.121, 3290.121)

[X] agree to update the emergency contact/parental consent form information whenever Changes occur or every 6 months at a minimum. (3270.124, 3280.124, 3290.124)

_____ _____

SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF CHILD'S WITHDRAWL	_____ _____ SIGNATURE-PARENT OR GUARDIAN DATE

PA PRE-K COUNTS ENROLLMENT FORM

(This information is confidential to the PA Pre-K Counts Program)

Date Form Completed: _____ / _____ / _____
MM DD YY

Last Name (Child)	First Name (Child)	Middle Initial

Street Address	County	
City	State	Zip Code
School District of Residence		

Home Phone	Work Phone	Email Address

Child's Date of Birth	Age please choos ☐ 2 ☐ 3 ☐ 4 ☐ 5	Male ☐ Female ☐

Race (optional)

- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Not Applicable
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Other

Please type race from the options listed as ethnicity and primary language

Ethnicity (optional)

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Not Applicable

Primary Language

- ☐ English
- ☐ Spanish
- ☐ Other _____ (please specify)

Name of Parent or Guardian completing this application	Gender ☐ Male ☐ Female

Relationship to Child please type one of the choices listed

- ☐ Father
- ☐ Mother
- ☐ Guardian
- ☐ Other _____ (please specify)

Relationship to Child please type one of the choices listed

- ☐ Biological
- ☐ Foster
- ☐ Adoptive
- ☐ Other _____ (please specify)

Please type one of the choices listed

- ☐ Primary Guardian
- ☐ Secondary Guardian
- ☐ Legal Guardian
- ☐ Other _____ (please specify)

Other Child Eligibility Risk Factor Criterion *(Must check all that apply):*

☐ Behavioral Supports: A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐ Child Protective Services: A child who is a foster child, a kinship care child or receiving Children and Youth Services
☐ Education Level of Guardian: Does not have high school diploma or GED or post-secondary degree.
☐ Individualized Education Plan (IEP): A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
☐ Incarcerated Parent: A child for whom one of the child's parents is currently in prison.
Homeless: A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following: A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinary used as a regular sleeping accommodation for human beings; C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.
☐ Migrant (Non-Immigrant)/Seasonal Student: A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
☐ Teen Mother: A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided in this application and the associated income documentation is accurate. I understand that I may be asked to verify or substantiate information provided.

_____ _____

Parent/Guardian (Signature) **Date**

_____

Parent/Guardian (Print Name)

Pre-K Counts Internal Checklist & Point Sheet

Child's Name: _____ Date of Birth: _____

Number of people in Family: _____ 5 years old on: _____

☐ Male ☐ Female Kindergarten ready September: _____

Local School: _____ Income: _____

Required Documents:

	2021 Federal Income Tax Return		Birth Certificate
	Social Security Card		Photo ID
	Completed Pre-K Counts Application		Proof of Residency (Mortgage or Lease)
	Proof of Residency		Immunizations
	Physical		Dental
	Vision		Hearing
	Parent Agreement		

One (1) Point for each item:

	300% of Poverty		250% of Poverty
	200% of Poverty		150% of Poverty
	100% of Poverty		Individualized Education Plan (IEP)
	Migrant/Seasonal Worker		English Language Learner
	Lives with another family		Welfare/Foster/Children & Youth/Kinship Care
	Mental Health/Behavioral Support/IEP		Teen Parent
	Incarcerated Parent		Single-Parent Household
	Parent has High School Diploma		On waitlist last year
	NSD Resident		Other:

Total: _____

Over Income: _____ Referred to Headstart: _____

Begin On: _____ Assigned to (Classroom/Teacher): _____

Reviewed By: _____ Date: _____

IEP/IFSP REQUEST FORM

Amazing Kidz Academy LLC Child Care Center strives to provide excellent quality childcare and education to all of the children that we serve. In accordance with requirements of the Keystone STARS Program all children that attend our childcare program and have an Individualized Education Plan (IEP – ages 3 and up) or an Individualized Family Service Plan (IFSP – under age the age of 3) must have a copy of these documents in the child's file. This copy will be kept confidential and will be reviewed by the Director and maintained by the teacher in the child's classroom. Our center will work closely with each parent as well as other agencies involved in the child's IEP/IFSP. If your child has an IEP or an IFSP, please provide a copy to our center so that we can place it in your child's file. Thank you in advance for your cooperation and understanding as we strive to best meet your child's individual needs.

Sincerely,

Amazing Kidz Academy LLC Administration

Please check the appropriate box:

☐ My child **does** have an IEP or an IFSP and I will submit a copy for your records

☐ My child **does not** have an IEP or an IFSP and I will submit a copy for your records

_____	_____	_____
Print Parent's Name	Parent's Signature	Date

_____	_____	_____
Director's Name	Director's Signature	Date

Dear Parent/Guardian:

Amazing Kidz Academy LLC 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 childcare. 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 childcare in your household **only** if the children in childcare 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: Amazing Kidz Academy LLC, 7120 N. Broad Street, Philadelphia, PA 19126.**

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) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

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 Federal Income Chart, shown on 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 childcare 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 should contact **Amazing Kidz Academy LLC.**

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.

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 **215-224-8000.**

Sincerely,

AMAZING KIDZ ACADEMY LLC ADMINISTRATION

Child and Adult Care Food Program
Child Enrollment Form (Sample)

Sponsor/Center Name: Amazing Kidz Academy LLC

Agreement # 326-51-803-7

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK: TIME-IN AM	TIME-IN PM	TIME-IN TIME	TIME OUT AM	TIME OUT PM	TIME OUT TIME	TIME CHILD ATTENDS SCHOOL: LEAVES CENTER	TIME CHILD ATTENDS SCHOOL: RETURNS TO CENTER	MEALS RECEIVED
FIRST CHILD NAME BIRTH DATE AGE	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK: TIME-IN AM**	**TIME-IN PM**	**TIME-IN TIME**	**TIME OUT AM**	**TIME OUT PM**	**TIME OUT TIME**	**TIME CHILD ATTENDS SCHOOL: LEAVES CENTER**	**TIME CHILD ATTENDS SCHOOL: RETURNS TO CENTER**	**MEALS RECEIVED**
SECOND CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY	☐ *Same Times as Above*								☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK: TIME-IN AM**	**TIME-IN PM**	**TIME-IN TIME**	**TIME OUT AM**	**TIME OUT PM**	**TIME OUT TIME**	**TIME CHILD ATTENDS SCHOOL: LEAVES CENTER**	**TIME CHILD ATTENDS SCHOOL: RETURNS TO CENTER**	**MEALS RECEIVED**
THIRD CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY	☐ *Same Times as Above*								☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

****

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:

(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.

Site 1: 1267 E. Cheltenham Avenue, Philadelphia, PA 19124 – 215-535-5439	Site 3: 7120 N. Broad Street, Philadelphia, PA 19126 - 215-224-8000
Site 2: 700 East Erie Avenue, Philadelphia, PA 19134 - 215 423-1000	Site 4: 4719 Rising Sun Avenue, Philadelphia, PA 19120 - 215-324-6000

www.amazingkidz123.com

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"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."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member regularly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL 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 ☐ Native Hawaiian or Other 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 Supplemental Nutrition Assistance Program (SNAP), 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; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

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

DO NOT FILL OUT 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

How often?

Weekly	Bi-Weekly	Monthly	2x Month
○	○	○	○

Household size

Categorial Eligibility ☐

Eligibility

Free	Reduced	Denied
○	○	○

Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date

CHILD HEALTH REPORT

(55 PA CODE 3270, 3280.131 AND 3290.131)

CHILD'S NAME: (LAST) (FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH: HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:	
FACILITY PHONE: COUNTY:	WORK PHONE:

☐ I authorize the childcare staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The childcare facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET, ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES, ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER;

HAS THE CHILD RECEIVED ALL AGE-APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATINS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.	
	VISION (subjective until age 3)	
	HEARING (subjective until age 4)	
	LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVRIUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSCIAN, CRNP OR PHYSCIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

CHILD DENTAL HEALTH /DENTAL EXAM FORM

Child's Name: _____ Date of Birth_____

SECTION 1: Completed by parent/guardian

1. Has your child been to the dentist? ☐ No ☐ Yes- if 'Yes", date of child's last dental visit_____
2. Does your child have (or had) cavities or caries? ☐ No ☐ Yes – if 'Yes', how many? _____
3. Does your child have any problems with his/her teeth, gums, or mouth?

   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth? _____

SECTION 2: Completed by child's Dentist

1. Date of child's most recent:

   Dental Examination _____ Teeth Cleaning _____ Fluoride Treatment_____
2. Has child ever needed dental treatment? ☐ No ☐ Yes

   If Yes, type of dental treatment _____

   Has dental treatment been completed? ☐ No ☐ Yes – if 'Ye', date of completion_____
3. Date of child's next dental visit: _____

Dental Office Stamp

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____