Thank you for your interest in Precious Cargo! We are excited for the opportunity to meet you and your family! Please note the following regarding this enrollment packet:

1. The enrollment fee is **due prior to your childs first day** of attendance. This fee is $45 for the 1st child and an additional $25 per child after.
2. The handbook outlines all of our policies that are important for you to know so please be sure to read it entirely.
3. Tuition is due every Friday for the following week of care. If your child is starting on a Monday, tuition for that first week will be due on their first day of attendance and then every Friday moving forward. Payments can be made on the Brightwheel app or cash/check payments can be made to the wooden box on the desk in the office. Any weekly payments made after 5:30pm on Mondays, will be considered late and a fee will apply. Please note that a 2.9% fee will be applied to payments made on Brightwheel with a card. No fee will apply if you submit your payment to Brightwheel via ACH.
4. *All documents (1 exception) on the right side of this folder must be returned at least THREE business days before your childs first day of attendance.* The 1 exception is the "Medical Statement"-you have 30 days from your childs start date to return this document.
5. Licensing requires all document to be filled out entirely. Please do not leave anything blank. NA may be used where applicable. Don't forget to sign and date where asked! 😊

Please don't hesitate to reach out with any questions! We want to ensure you are comfortable and prepared to join our PC family!

Ms. Sara

Precious Cargo
Preschool & Childcare

Family Information

Childs Name:_____
Nickname:_____

Who lives at home with your child?
What is the primary language spoken in your childs home?
Are there any special family arrangements, such as shared parenting living in two homes, or custody specifications? Additional details?
Are there any changes or transitions that your child has recently experienced? Additional details?
Are there any cultural or religious practices that we should be aware of?
Do you have pets at home? If so, what are they and what are their names?
Has your child had a previous care arrangement? If so, additional details (center based, in home based, family etc.)?
Are there any personality/behavior characteristics that would be useful for us to know about your child?
What frightens your child? How do they like to be comforted?

What methods do you use to respond to your childs negative behavior?
Is your child toilet trained? If not, have you started the training process yet? If so, what is your process?
What is your childs sleep schedule? Does your child have trouble sleeping (night terrors, trouble going to sleep, etc.)?
Please describe your childs temperament (sensitive, irritable, active, passive, happy, aggressive, etc.)
What are your expectations of the program?
Has your child received any educational, therapy, counseling, etc. services? If so, please explain.
What concerns do you have about your childs development or behavior?
Is there any other information that you feel would be useful for us to know about your child and or your childs family?

Does your child have any difficulty or delay in the following areas? If so, please describe.

Communication skills:

_____

Oral motor skills:

_____

Motor skills:

_____

Independent living skills:

_____

Patterns of emotional adjustment

Do you consider any of the following to be a problem for your child at this time?

- Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- Talks excessively, interrupts often, doesn't listen
- Often depressed/irritable mood
- Low energy/fatigue
- Shy
- Often loses things, very disorganized compared to others of his/her age
- Difficulty completing tasks
- Difficulty following instructions
- Engages in impulsive behavior (acts before thinking)
- Often actively defiant to adult requests and rules
- Somatic complaints of not feeling well
- Excessive separation difficulties
- Easily frustrated
- Withdrawn
- Difficulty making decisions
- Aggression towards others
- Unrealistic worry about future events
- Difficulty adjusting to change in plans or routines
- Lack of awareness or sensitivity to the need or feelings of others

Name of person completing
form:_____

Relationship to child:_____

Signature:_____
Date:_____

Reset Form

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ 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 - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation**.**

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*

☐ No (If no, fill out the following:)

The program's policy is to check diapers every 2 hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport		**OR** Do not sign both	***Do Not Give Permission* to Transport**	
Program or Home Name Precious Cargo Preschool & Childcare			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Reset Form

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below)*:

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below)*

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER: ☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	**Initials of Examining Health Care Practitioner**
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent**
	Date

Parent Permissions

CHILD ATTENDANCE SCHEDULE

My child _____ will be attending Precious Cargo Preschool & Childcare

-PLEASE CIRCLE WHICH DAYS YOUR CHILD WILL ATTEND-

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

FROM: _____a.m. TO: _____p.m.

PHOTOGRAPH/ASSESSMENT PERMISSION

I give Precious Cargo Preschool & Childcare permission to take my child's photograph. I understand that the photographs taken could be used for classroom activities as well as for advertising and promotional purposes. If you consent to photos in portfolios and in the classroom but not online – next to your signature please write "no web".

_____ _____

PARENT SIGNATURE **DATE**

I give Precious Cargo Preschool & Childcare permission to use screening and assessments tools to aid in evaluating child's development. Once the assessment tool is completed, it will be stored in child's individual portfolio and teachers will refer to it when creating weekly plan of activities.

_____ _____

PARENT SIGNATURE **DATE**

PREFERRED COMMUNICATION

Please rank your preference from 1 to 4, with 1 being the most preferred, for how you would like to receive communication from Precious Cargo Preschool & Childcare.

_____ Phone Call #:_____ _____ Text Message #:_____

_____ Letter sent home with child _____ Email :_____

Please sign me up to receive information & alerts from Precious Cargo Preschool & Childcare via **Brightwheel**. I understand this program is completely voluntary and understand that this is a way of communication with my childs teacher.

Name/#:_____

Name/#:_____

Email can be used for a number of different reasons, such as, introducing new software, sending electronic copies\documents, Eblasts, order forms, etc. Please provide email(s) for any parent\guardian.

Name:_____ Email:_____

Name:_____ Email:_____

Precious Cargo
Preschool & Childcare
1120 N. Johnson Rd.
Sebring, OH 44672
(330) 938-1120
preciouscargo1120@yahoo.com

Authorized Pick-up List

Name of child(ren):

Date Added	*Name of authorized person*	*Relationship to child*	*Phone number*

Parent Signature *Date*

CHILD AND ADULT CARE FOOD PROGRAM
INFANT MEALS – PARENT PREFERENCE LETTER

TO: **Parents and Guardians of Infants under one year of age**

FROM:	**NAME OF CENTER/PROVIDER**	

TOPIC: **Who will provide food for your infant's meals?**

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a U.S. Department of Agriculture (USDA) child nutrition program. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

NAME OF FORMULA	

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section. When a child is developmentally ready, parents may provide only one food component as part of a reimbursable meal or snack.

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

☐ I want the center or FCC home provider to provide formula for my infant

☐ I will bring iron fortified infant formula for my infant

Parent/Guardian: List Name of Formula You Will Provide

☐ I will bring expressed breast milk for my infant

☐ I will come to the center or FCC home to breast feed my infant

Solid Food: (check one)

☐ I want the center or FCC home to provide all solid foods for my infant when he/she is developmentally ready

☐ I will bring one solid food item for my infant when he/she is developmentally ready for it and the center will provide all other required components

***Note: If your feeding preferences change, you will be asked to complete a new form.**

INFANT NAME:	**INFANT BIRTHDATE:**
PARENT/GUARDIAN SIGNATURE:	**DATE:**

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.
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Reset Form

Ohio Department of Job and Family Services

DEVELOPMENTAL AND EDUCATIONAL GOALS FOR STEP UP TO QUALITY (SUTQ)

Name of Child	Date of Birth

For Three to Five-Star Rated programs, the program must work with families to develop goals for children. These goals must be updated at least annually.

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Lead Teacher's Name	Signature	Date

Parent/Guardian's Signature	Date

Name of Child	Date of Birth

Additional goals or updates to currently listed goals

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Lead Teacher's Name	Signature	Date

Parent/Guardian's Signature	Date

Reset Form

Ohio Department of Job and Family Services

BASIC INFANT INFORMATION FOR CHILD CARE

This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.

Child's Name	Nickname
Child's Date of Birth	Siblings

What are you feeding your infant? *(Check all that apply)*

☐ Formula (include brand) ☐ Breast milk

Formula preparation *(if center/provider is to prepare.)*

Amount for each feeding	Frequency of feedings

My infant likes a bottle warmed: *(Check one)* ☐ Room temp ☐ Warm ☐ Very warm/NOT HOT

Juice *(type, amount, when?)*

Does child use a cup yet? ☐ No ☐ Yes

Solid foods *(baby food, brand, types, amounts, frequency)*
**you must have written permission from your child's physician if your child is under 4 months and given solid foods.*

Are foods served room temperature or warmed?

Table food *(types, amounts, frequency, special instructions)*

Security items *(pacifier, blankies, etc.)*

Nap schedule

Hints for getting baby to sleep

Sleeping Position ☐ Back ☐ Side* ☐ Tummy*
**You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.*

Special Precautions

Any additional information about your child that would be helpful or you would like staff to know.

Parent Signature	Date
Primary Caregiver Signature	Date

Date form last updated					

Child and Adult Care Food Program (CACFP) Enrollment Form

Requirements:

a. CACFP child care centers and Head Start centers must have a completed CACFP Enrollment Form on file for each enrolled child. Siblings must have a separate form as attendance may be different.

b. The CACFP Enrollment Form is valid for 12 months following the month of parent/guardian dated the form. For example: Parent dated the form on 7/13/2019; form would expire on 7/31/2020). CACFP Enrollment forms must be completed annually by parent/guardian.

c. The following CACFP program types DO NOT need CACFP Enrollment forms:
   - Outside-School Hours Centers
   - Youth Development Programs
   - After School at Risk Programs
   - Emergency Shelters

Enrollment Form Reminders

- List one child per form
- All parts of form to be completed by parent/guardian including normal days, hours and meals
- If parent/guardian work schedule varies frequently thus the child's attendance pattern also will change frequently then parent should check the box at the bottom of the chart. Parent/guardian is not required to complete another form but may elect do so.
- For ease of collection, it is highly recommended that agencies/centers distribute enrollment forms to parents/guardians at the same time as the income eligibility application so that it is more likely that the forms would expire on the same date.
- If sponsor decides to develop own CACFP enrollment form, form contain all required information and be approved by state agency prior to use.

ATTACHMENTS

- State Agency Prototype CACFP Enrollment Form
- Example of completed CACFP Enrollment form

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME		
CHILD'S NAME (please print)	**AGE**	**BIRTHDATE** / / month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		**List hours child normally in care**				**Check (✓) meals child normally receives while in care**					
		Arrive	**Depart**	**Arrive**	**Depart**	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Supper**	**Evening Snack**
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ **Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.**

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**

MAILING ADDRESS:
STREET /APT. **CITY** **ZIP CODE**

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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;

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(3) email:program.intake@usda.gov.

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CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME *Sunshine Child Care*

CHILD'S NAME (please print)	**AGE**	**BIRTHDATE**
ANNIE JONES	**5**	**9** / **4** / **2009** (month / day / year)

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List hours child normally in care				Check (✓) meals child normally receives while in care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday	✓	7:00 am	8:15 am	4:15 pm	6:00 pm	✓			✓		
Tuesday	✓	7:00 am			6:00 pm	✓		✓	✓		
Wednesday	✓	7:00 am	8:15 am	4:15 pm	6:00 pm	✓			✓		
Thursday	✓	7:00 am			6:00 pm	✓		✓	✓		
Friday	✓	7:00 am	8:15 am	4:15 pm	6:00 pm	✓			✓		
Saturday											
Sunday											

EXAMPLE

☐ **Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.**

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**
Mary Jones	*7/13/2019*	*(614) 222-3344*

MAILING ADDRESS:
STREET /APT. *123 Park St.* **CITY** *Columbus* **ZIP CODE** *43215*

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(3) email:program.intake@usda.gov.

This institution is an equal opportunity provider. Revised 8/2021

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2021-2022

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an a*dult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME		**CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)**	**PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBE CONTAINS 7 DIGITS.**	
PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER			Check type of benefit:	□ FOOD ASSISTANCE (SNAP) or □ OHIO WORKS FIRST (OWF)
* NAME OF ENROLLED CHILD(REN)	AGE / BIRTH DATE			
1.		☐	CASE NO.	__ __ __ __ __ __ __
2.		☐	CASE NO.	__ __ __ __ __ __ __
3.		☐	CASE NO.	
4.		☐	CASE NO.	

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	☐	$ amount / how often	$ amount / how often	$ amount / how often	$ amount / how often
1.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
6.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* **SIGNATURE OF ADULT HOUSEHOLD MEMBER**	* _____ **DATE**	* **If Part 3 is completed, insert last 4 digits of Social Security Number** ☐☐☐☐ ☐ **(Check if applicable) I do not have a Social Security Number**
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

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

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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.

State Distribution: July 2021

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion : Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12		Application Certified/Categorized as: ☐ **FREE,** based on □ Food Assistance/OWF Case No. □ Household size and income □ Foster Child ☐ **REDUCED**, based on Household size and income
Total Household Size: _____	**Total Household Income: $**_____ Per: □ week □ every two weeks □ twice per month □ month □ year	☐ **PAID,** based on □ Income too high □ Incomplete □ Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date (From the first of month of date signed)	Expiration Date (Valid until last day of month in which form was signed one year earlier)

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

PARENT RESOURCES

Jobs & Family Services

449 S Meridian St. Ravenna, OH 44266 (330)297-3750

Food Pantries

Center of Hope

1081 W Main St. Ravenna, OH 44266 (330)297-5454

Alliance Community Pantry

215 E Market St. Alliance, OH 44601 (330)680-8130

Libraries

Reed Memorial

167 E Main St. Ravenna, OH 44266 (330)296-2827

Mahoning Public

305 Wick Ave. Youngstown, OH 44503 (330)744-8636

Salvation Army

1501 Glenwood Ave. Youngstown, OH 44511