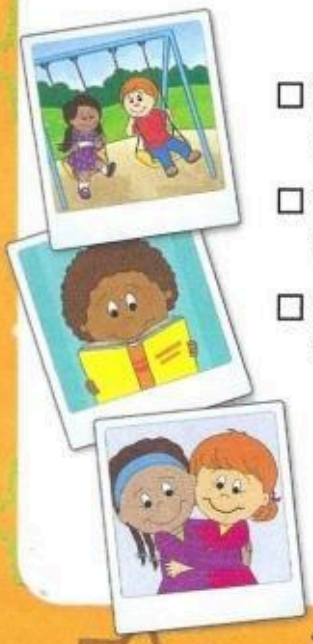
Amy's Angels Child Care

Child's Name:_____ DOB:_____

Photo Authorization Form

We would like to capture photos of your child(ren) and their daily activities to be used for FB, Brightwheel, website.



Choose one of the following options:

☐ Yes, I authorize photos of my child(ren), _____, to be taken and published for use by the provider.

☐ Yes, I authorize photos of my child(ren), _____, to be taken but only to be shared with me and NOT published in any form.

☐ No, I do not authorize photos of my child(ren), _____, to be taken or published in any form.

_____ _____
Parent(s) Signature Date

_____ _____
Provider's Signature Date

Amy's Angels Child Care

Child's Name:_____ DOB:_____

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -
CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:
CHILD'S HOME ADDRESS:		
NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____	
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text **EMAIL ADDRESS:**	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):	

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	***FOR PROGRAM USE ONLY*** DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child..... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year..... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

Child's Name:_____ DOB:_____

Child Information Sheet

Child's Name: _____ DOB:____/_____/_____
Days Attending: M T W TH F Approx Time Of : **Drop Off**:_____**Pick Up**:_____
Parent/ Guardian Names: _____ / _____
Child Lives With:
☐Own Mother ☐Own Father ☐Step Father ☐ Step Mother ☐ Other: _____
Parents are: ☐ Married ☐ Single ☐ Divorced ☐ Separated
Mom + Dads employment:_____/_____
Mom + Dads email:_____/_____
*Communication methods that work the best:_____
Is there any custody information Amy's Angels should be aware of?_____
_____
Has your child ever been in a Daycare before? ☐ Yes ☐ No If yes,describe_____
Child's Ethnic Background: ☐ African American ☐ Arabic ☐ Asian/Pacific Islander ☐ Hispanic ☐ American Indian ☐ White ☐ Bi-Racial ☐ Other: _____
What is your cultural heritage?_____
How does your heritage influence your family traditions, routines and celebrations?____
_____
What language(s) is spoken in the home? ☐ Mostly or only English ☐ Some English ☐ Another language and English equally ☐ No English ☐ Other language(s):_____
Has your child been identified as having special needs?: ☐ Yes ☐ No
If yes, by whom?_____
Do YOU feel your child has special needs? ☐ Yes ☐ No
Please describe:_____
Does your child have an active Individual Family Service Plan (IFSP)? ☐ Yes ☐ No
List any special services your child has received since birth:_____
_____
What are your hopes for your child at Amy's Angels Child Care?_____
_____
Does your child have any allergies? ☐ Yes ☐ No If Yes, Describe:_____
Is your child on any medications? ☐ Yes ☐ No If yes, Describe:_____

Date of enrollment:_____

Child's Name:_____ DOB:_____

Parent Questionnaire

Dear families,
Please complete this questionnaire to help us learn more about your child and family. This information will help us provide an environment for diverse learning and accommodate different developmental levels, interests and goals. Research shows that children with strong childcare-parent-community connection have the most success. We appreciate your taking the time to fill this form out.

Parents/Guardians:_____/_____
Other important people in the child's life:_____
Describe what you have noticed about infant's personality so far:_____
_____
_____
What are your child's favorite activities at home?_____
_____
What are some of your child's strengths:_____
_____
Which routines/ parts of the day are easy?_____
_____
Why?_____
Which routines/ parts of the day are difficult?_____
_____
Why?_____
What are some of your child's interests?_____
_____
What do you enjoy doing as a family?_____
_____
Who tracks your child's developmental milestones with you?_____
Does your child receive any therapies?_____
Is there anything away from our setting that may be affecting your child's behavior?____
_____
What learning & growth goals do you have for your child(short-term and/or long-term)?
_____
_____
Please list other topics or questions you would like to talk about._____
_____
_____

Child's Name:_____ DOB:_____

Celebrating Holiday's Family Questionnaire

Dear Families,

Your answers to the following questions will guide the development of an inclusive appropriate approach to celebrating holidays. The goal is to host celebrations and plan for activities that meet the needs of all children and families in this setting. Thank you for taking the time to share this information.

1.Which special occasions and holidays do you celebrate in your family?

_____

_____

_____

2. How do you commemorate special occasions and holidays?

_____

_____

_____

3.Would you like your child to celebrate holidays at daycare? ☐ Yes ☐ No

(If you answer NO, skip to question 7)

4. How do you feel about the possibility of your child learning about holidays that are not celebrated in your home?_____

_____

_____

5.What would you like your child to gain from holiday activities occurring at daycare?_____

_____

_____

6.How would you like to participate in holiday activities occurring at daycare?

_____

_____

7.What concerns, if any, do you have about your child participating in holiday activities?

_____

_____

_____

8. If your family does not celebrate holidays, what kind of support would you like if/when there are holiday activities? _____

_____

Child's Name:_____ DOB:_____

INFANT FEEDING ROUTINE & AGREEMENT

(Please Note: By Law, Amy's Angels cannot administer any medication without written permission from a doctor. Please get forms from the center's office) Provided formula: Parents choice Gentle with iron

Infant Feeding: We can not feed any solid foods until this form is filled out and signed by the infant's parent/guardian. This form must be updated when your infant turns three (3) months and six (6) months old

Check all that apply: ☐Breastmilk(Provided by Parents)☐Formula(Provided by Parents)
☐ Whole Milk(12+Months) ☐ Other(With doctor's note)
How often does the baby feed?_____ Aprox. # of ounces per fluid feeding _____
Mixing instructions for formula fed babies:_____
Type of formula for formula fed babies:_____
Baby's preferences(Warm,Cold, How Held)?_____
Burping Habits?_____
(If you have any special requests regarding the last feeding of the day, Please let us know!)

Age: 3 months:
Choose your preference: ☐ Amy's Angels Food ☐ I will provide my own foods
☐ I would like solid foods (Infant Cereal) to be added to my child's meals.
Instructions:_____
_____
☐ I do not want solid foods added to my child's meal at this time.

Age: 6 months:
☐ I would like to add solid foods to my child's meals (check all that apply)
- ☐ Infant cereal
- ☐ Infant Fruits
- ☐ Infant Vegetables
- ☐ Meat/ meat alternatives

Instructions:_____
☐ I do not want my child served solid foods.
Food Preferences (Consistency, Temps, OR anything they should NOT have)
_____

_____ _____
Parent Signature Date

Child's Name:_____ DOB:_____

Sleeping Routine & Agreement

- As a result of OCFS regulation changes, Effective June 1, 2015, all childcare programs are required to have on file a written agreement regarding nap time for each child in care.
- Children in Toddler and Preschool classrooms sleep on a firm cot. Parents are asked to provide a blanket large enough to cover the child with.
- Cots are numbered and assigned to individual children. Cots are disinfected daily after nap.
- Cots are positioned around the classroom(minimum of 2 ft apart) And in fuul view of staff. Cots are positioned so they are not in the way of exits and do not create trip hazards.
- Evacuation drills are practiced during nap time at least 1x per year to ensure safe evacuation during all times of the day.
- Children are not allowed to sleep with their head covered to ensure they can be observed and monitored while napping.
- Children unable to sleep within the first 30 mins will be provided with a quiet supervised activity within the classroom.

Infants:
What time does baby normally rise in the morning?_____
How often does baby normally nap?_____
Naps usually last how long?_____
How does baby usually fall asleep?(Please note: Putting infants to sleep on their stomach is unsafe and is prohibited by regulation) ☐On Back ☐On Side ☐With a comfort Item ☐Pacifier ☐ Other_____
What else should we know about your baby's nap routine?_____
What soothes baby ☐ Special toy ☐ Pacifier ☐ Rocking ☐
Other:_____

Infant 12-18 Months:
☐ I agree that my child can sleep on a cot during nap time between 12-18 months of age
☐ I would rather my child between 12-18 months of age to sleep in a crib

Toddler and Preschool:
What time does your child normally nap?_____
Naps usually last how long?_____
How does your child usually fall asleep?(Position, comfort item, etc.)_____
_____
What else should Amy's Angels know about your child's sleep routine or habits?_____
_____

_____ _____

Child's Name:_____ DOB:_____

Parent Signature Date

Amy's Angels Child Care

Child's Name:_____ DOB:_____

Authorization to Release Child

Unless otherwise authorized by you in writing, no one but you, your spouse, or emergency contact person may pick up your child(ren) from this setting.

I, _____, give authorization for the following contacts to pick up my child(ren) _____
Child(ren)'s Name(s)

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

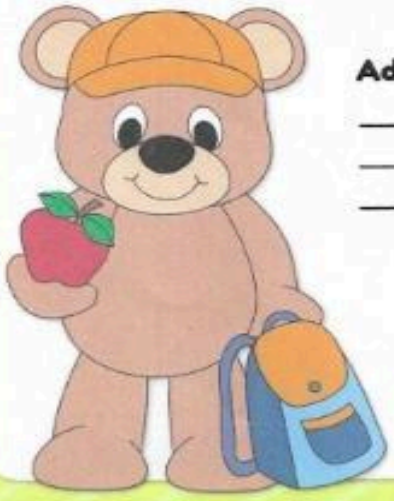
Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____

Name: _____ **Relationship:** _____

Phone Number: _____



Additional Comments: _____

_____

_____

_____

_____
Parent(s) Signature

_____
Date

_____
Provider's Signature

_____
Date

*FunShine Express

Child's Name:_____ DOB:_____

Permission to Release Information

Please complete the form below giving us permission to communicate, share, and receive information with IEP/IFSP team members, EI/CPSE officials, and health care providers involved in your child's care. This will enable Amy's Angels Child Care to receive essential IEP/IFSP documents or any other pertinent information that will enable continuity of support for your child while in our care.

Child/Parent Contact Information

Child's Name_____Date of Birth_____
Parent/Guardian_____Relationship to the Child_____
Home Address_____
Primary Phone Number (s).
_____/_____
E-Mail_____

Parent Consent for Release of Information

I give permission for the following professionals/officials to share all pertinent information regarding my child with Amy's Angels Child Care. (Please check the boxes that apply and print names of the following individuals with whom you give consent. Please write LEGIBLY.)

☐ Child's Pediatrician: _____
☐ School District: _____
☐ Service Coordinator/Agency: _____
☐ Other: _____

_____ _____
Parent Signature Date

Child's Name:_____ DOB:_____

Emergency Medical Release

I give Amy Yencer or any staff of Amy's Angels Child Care permission to obtain life-saving medical treatment for my child/children when I can't be reached.

The "Blue Card" will be given to EMS personnel to be taken to the hospital which also gives medical personnel permission to provide care.

Child's name: _____

Child's name: _____

Child's name: _____

Child's name: _____

_____ _____

Parent/Guardian Date

Sworn to me this _____Day of _____, 20____

_____

Notary Public of the State of New York (Affix Stamp)

Child's Name:_____ DOB:_____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I,_____, (Applicant) residing at _____

_____, New York, do herby authorize the Livingston County Department of Social Services to release to _____, (day care provider), the following information as to the status of my application for daycare assistance eligibility as follows:

[Check all that apply]

____ Whether I have applied for day care assistance

____ Whether I have handed in all of my paperwork needed to determine my eligibility

____ Whether my application has been accepted for review;

____Whether I am eligible for daycare assistance

____ If I am eligible , the effective day of my day care assistance

____ My recertification date.

____ If I have not handed in all paperwork necessary to recertify, you may call my provider to advise them of this, so that they may remind me to complete the paperwork.

____ My welfare examiner may discuss all information about my daycare case with my day care provider as long as it pertains to daycare only.

____My daycare provider may be provided with my welfare examiner's name and case number

____ My daycare provider may be advised of any change in my case status, including and changes to the parent fees.

____ My daycare provider may be advised if my case is/will be closing, regardless of the reason.

____My daycare provider may be consulted with regard to the hours that I utilized daycare for my child/children.

____ My daycare provider may be advised with regard to my place of employment.

____ Other [Specify]:

_____
_____
_____

____ All of the above

This release shall continue in full force and effect until I no longer am using this particular daycare provider, or until my case is closed, whichever first occurs.

_____
_____

_____ _____

Date Applicant

Amy's Angels Child Care

Child's Name:_____ DOB:_____

Sunscreen

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:
	See package instruction	Topical

7A. Frequency to be administered, include times of day if appropriate: as needed

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☒ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☒ Contact parent _____

Other (describe): _____

10A. Special instructions: ☒ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): ***Prevent sunburn***

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:
Amy's Angel's Child Care	904282	585-883-8060

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:
Amy Yencer	

21. Staff's signature:

X Amy Yencer

Child's Name:_____ DOB:_____

Bug Spray (optional)

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

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- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:
	See package instruction	Topical

7A. Frequency to be administered, include times of day if appropriate: as needed

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☒ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B. Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☒ Contact parent

Other (describe): _____

10A. Special instructions: ☒ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): ***Prevent big bites***

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:
Amy's Angel's Child Care	904282	585-883-8060

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:
Amy Yencer	

21. Staff's signature:

X Amy Yencer

Amy's Angels Child Care

Child's Name:_____ DOB:_____

Diaper Cream

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

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- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:
	See package instruction	Topical

7A. Frequency to be administered, include times of day if appropriate: as needed

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☒ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☒ Contact parent

Other (describe): _____

10A. Special instructions: ☒ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): ***Prevent and treat diaper rash***

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:
Amy's Angel's Child Care	904282	585-883-8060

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:
Amy Yencer	

21. Staff's signature:

X Amy Yencer

Amy's Angels Child Care

Child's Name:_____ DOB:_____

OCFS-LDSS-4433 (Rev. 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date OR 1st Date (if given on or after 15 months of age) / /	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

Child's Name:_____ DOB:_____

OCFS-LDSS-4433 (Rev. 08/2019)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam
Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date

Child's Name:_____ DOB:_____

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME_____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children

_____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR THE CHILDCARE CENTER TO COMPLETE

CACFP Agreement # _____

Total Number of Household Members (INCLUDING FOSTER CHILDREN, IF APPLICABLE) _____

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will receive Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER | | | | |

Date _____

This institution is an equal opportunity provider.

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