



Total Weekly Fee _____
CCR _____ EEC _____
Parent fee _____
Registration Fee \$20.00 _____
Received by PG _____
OFFICE USE ONLY

The Commonwealth of Massachusetts
 Department of Early Education and Care Child's Enrollment Form
Boys & Girls Club of Greater Westfield Pre-School

Child Information

Name: _____ Date of Birth: _____

Age at Admission: _____ Date of Admission: _____

Address: _____

Primary Language: _____ Identifying Marks: _____

Eye Color: _____ Hair Color: _____ Race: _____

Gender: _____ Height: _____ Weight: _____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child?
 If yes, please attach. _____

Parent/Guardian Information

Parent/Guardian Name: _____ Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____ Email Address: _____

Business Name: _____ Business Address: _____

Business Phone Number: _____ Hours at Work: _____

**TRANSPORTATION PLAN AND AUTHORIZATION [7.09 (3) and 7.12 (1)]
& EMERGENCY CONTACTS**

I give permission for my child to be released from the program at the end of the day as stated above and/or I give my permission to the following people to receive my child at the end of the day. (If no one is authorized, please indicate below by writing (“**NO ONE**”) I will call the program to notify of a change in pick-up and the substitute will show picture identification to the staff.

1. NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

2. NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

3. NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

4. NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

5. NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITING AND MAINTAINED IN THE CHILD’S FILE OR THE ABOVE PLAN MUST BE IMPLEMENTED. THIS PERMISSION IS VALID FOR ONE PROGRAM YEAR FROM THE DATE OF SIGNATURE.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility to secure necessary medical treatment for my child.

Medical Information: Child's Physician: _____ Phone: _____

Insurance Carrier: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food allergies/reactions: _____

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Regular medications: _____

Have there been any traumatic situations in your child's life? IE death, divorce, etc. _____

Individual Health Plan for child with a chronic health condition?

If yes, please attach. _____ **No my child has no chronic health condition** _____

Special limitations or concerns: _____

Eating Habits

Favorite foods: _____

Foods refused: _____

Toilet Habits

Are disposable or cloth diapers used? _____ Is there frequent occurrence of diaper rash? _____

Do you use: oil ___ powder ___ lotion ___ other _____

Are bowel movements regular? _____ How many times per day? _____ Constipation? _____

Diarrhea? _____ Has toilet training been attempted? _____

Please describe any particular procedure to be used for your child at the Club: _____

What is used at home? Potty chair _____ Special child seat _____ Regular seat _____

How does your child indicate bathroom needs? (include special words): _____

Is your child ever reluctant to use the bathroom? _____ Does your child have accidents? _____

Sleeping Habits

Does your child sleep in a bed? _____ crib? _____ Does your child become tired or nap during the day (include when & how long) _____

What time does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking etc.) _____

Ways in which you prepare your child for sleep: _____

Social Relationships

How would you describe your child's personality? _____

Circle all words that describe your child: Serious Happy Quiet Polite Artistic Independent Energetic Shy
Active Patient Loud Affectionate Outgoing Easygoing Aggressive Eager Intense Compassionate
Adventurous Timid Friendly Reserved Spirited Moody Fussy Easily distracted Persistent

Reaction to strangers? _____ Able to play alone? _____

Does he/she have a favorite toy or lovey? (example: pacifier, stuffed animal, blanket etc.) _____

Fears (the dark, animals, etc.) Animals _____ Loud noises _____ Thunderstorms _____

Strangers _____ Dark _____ Change in routine _____ other _____

How do you comfort your child? _____

What is the method of behavior management/discipline at home? _____

What would you like your child to gain from this experience? _____

Has your child ever been in care before? If so, what type, why did they leave? Family Child Care, Center Care,
nanny or family member? _____

Please describe your child's schedule on a typical day. _____

Is there anything else we should know about your child? _____

Family Background Information (Please fill out this form in order for us to get to know you and your family better)

Who lives with your child? (other than parents/guardians)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

What language is your child's first language? _____

Any speech difficulties? _____

Is he/she exposed to any other languages at home or with family? _____ If yes what language? _____

Do you have any pets? _____

Has your child ever had a developmental evaluation done by a medical professional or early intervention? _____
If yes does your child receive any services either currently or in the past?

If so, would you share your child's IFSP, IEP or evaluation results and allow the staff to communicate with any of
the professionals who work or worked with your child? _____

Permission for Use of On-Site Swimming Pool

I hereby give **The Boys & Girls Club of Greater Westfield Inc.** permission to allow my child

_____ who is _____ years old

Childs Name

Age

to use the on site swimming pool at the program. I understand that my child must be directly supervised by the Lifeguard at all times, and that there will be a second adult on the premises to assist in case of an emergency whenever the pool is in use.

***Disclosure:** Before being allowed in the pool, your child will need to complete a swim test. There are two swim tests: one for the shallow end and one for the deep end. To pass the shallow end test, your child must swim across the width of the pool without touching the wall or the bottom. If they wish to go into the deep end, they must wear a life jacket. To pass the deep end test, your child must swim the full length of the pool without touching the wall or the bottom. You will be notified once your child successfully completes their swim test.

Parent's/Guardian's Signature

Date

Swimming Abilities

Always needs a swimming device in the water

Y N



BOYS & GIRLS CLUB

NOTE: This information is strictly confidential and is collected for grant writing purposes only

Name: _____ Birth date _____

Ethnicity: African American, Asian, Caucasian, Hispanic, Multi-Racial, Native American, Pacific Islander

Member lives with: __ Mom & Dad __ Mom __ Dad __ Step Mom __ Step Dad __ Grandparent
__ Foster Parents: Other: _____

Head of Household: ____ M ____ F ____ Both Single Parent: ____Y ____N

Household Size: _____ Number under 18 in Household: _____

Member of the Household 65 years old or older: ____Y ____N

Member of the Household Handicapped: ____Y ____N

School Lunch: ____Free ____Reduced ____Not applicable

Parent or Guardian in the Military:

____Y ____N Branch _____ Base _____ Rank _____

Status: Guard Reserve Active

Please initial below

I understand weekly payments must be made by Friday or I will pay a \$10.00 late fee _____

I understand that there are no refunds or make up days for missed days. _____

Weekly fees are paid even if your child does not attend. _____

Picking up your child past 5:30 pm could result in late fees. _____

I give permission to use member in positive publicity in video, print, and photos. YES _____ NO _____

Copy of Immunization Records. YES _____ NO _____

CITY OF WESTFIELD- OFFICE OF COMMUNITY DEVELOPMENT

SELF-DECLARATION OF INCOME REPORT / PY2025 (CDBG)

FY2026 (CITY)

(Effective June 1, 2025)

Federal regulations require we obtain this information to document assistance is being provided to low and moderate-income households. The Participant/Guardian should complete this form indicating all persons residing within their household, regardless of whether or not they are related. The Grantee should retain this form for monthly reporting requirements as well as for on-site monitoring visits.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITH ANY OTHER AGENCIES

PLEASE NOTE: ALL FOUR SECTIONS OF THIS FORM MUST BE COMPLETED TO RECEIVE REIMBURSEMENT

PARTICIPANT INFORMATION

1. PARTICIPANT STATUS: FAMILY INDIVIDUAL

Participant Name: _____

Address: _____ City, State, Zip Code: _____

2. ETHNICITY (please select only one):

Hispanic or Latino Not Hispanic or Latino

3. RACE (please select only one):

- | | |
|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian/Alaskan Native <i>and</i> White |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian <i>and</i> White |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American <i>and</i> White |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> American Indian/Alaskan Native <i>and</i> Black/African American |
| <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> Other Multi-Racial: _____ |

4. HOUSEHOLD INFORMATION

1) Choose the row with the number of family and non-family members living in your household below.

2) Circle the corresponding income level. (Median Family Income) – Effective June 1, 2025

Household Size	#1 (0%-30%)	#2 (31%-50%)	#3 (51%-80%)	#4 (81% and above)
1	\$0-\$25,150	\$25,151-\$41,850	\$41,851-\$67,000	\$67,001+
2	\$0-\$28,750	\$28,751-\$47,800	\$47,801-\$76,550	\$76,551+
3	\$0-\$32,350	\$32,351-\$53,850	\$53,851-\$86,100	\$86,101+
4	\$0-\$35,900	\$35,901-\$59,800	\$59,801-\$95,650	\$95,651+
5	\$0-\$38,800	\$38,801-\$64,600	\$64,601-\$103,350	\$103,351+
6	\$0-\$41,650	\$41,651-\$69,400	\$69,401-\$111,000	\$111,001
7	\$0-\$44,550	\$44,551-\$74,150	\$74,151-\$118,650	\$118,651+
8	\$0-\$47,400	\$47,401-\$78,950	\$78,951-\$126,300	\$126,301+

I certify the above information is true and correct to the best of my knowledge.

Participant/Guardian: _____
(Original signature is required)

Date: _____



Dear Family & Staff,

Please let this letter serve as verification that you agree to visit www.bgcwestfield.org and review the following documents:

- Current Parent/Staff Handbook
- Safety Policy
- Technology Policy
- Video Surveillance Policy

Should you have any questions regarding any of the above documents please bring your questions/concerns to our Childcare Director, Pre-School Director or Program Director.

By signing below, you agree to abide by the policies/documents set forth by the Boys and Girls Club of Greater Westfield and further agree that your child(ren) must adhere to the requirements listed in all policies/documents listed above to participate in the Kidz Klub/General Membership Programs.

Please print each of your Child(rens) Names:

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____

Staff Name Printed: _____

Staff Signature: _____

Date of Agreement: _____

Staff taking in form: _____



PERMISSION SLIP

What: Topical Sunscreen and Bug spray

Who: Preschool Rooms

I Parent/Guardian _____ give permission to The Boys & Girls Club of Greater Westfield to apply topical sunscreen to my child.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____

Meal Benefit Income Eligibility Application Packet
Child Care Institutions

Document Index

This document contains the following information:

1. Robert M. Leshin Memo re: Meal Benefit Income Eligibility Applications
2. Instructions for Child and Adult Care Food Program Centers and Sponsoring Organizations.
3. Letter to Parent/Guardian
4. Instructions for Household
5. Meal Benefit Income Eligibility Application (Child Care)
6. Sharing Information with Medicaid/SCHIP
7. Mass Health Flyer



MEMORANDUM

To: School Nutrition Directors
From: Robert M. Leshin, Director, Office for Food and Nutrition Programs
Date: July 1, 2025
Subject: School Food Authorities Sponsoring CACFP After School Programs (At-Risk, Child Care and Outside School Hours Programs)

Attached are the updated prototype materials for households applying for free or reduced price meals in the Child and Adult Care Food Programs. The *Healthy, Hunger-Free Kids Act of 2010*, the child nutrition federal reauthorization law, made several changes to eligibility. Based on input from several sources, we have designed a Massachusetts Family Household application that streamlines the application and instructions. USDA application packages are available in multiple languages at <https://www.fns.usda.gov/cacfp/english-meal-benefit-income-eligibility-form>.

This package, located online in the Online Document and Reference Library, includes forms and letters for Sponsors and institutions to use.

Reminders:

- Children enrolled in Federally-funded Head Start centers are categorically eligible for free meal benefits.
- Children designated as homeless are categorically eligible for free meal benefits.
- Foster children are categorically eligible for free meal benefits. An application is not needed, but there does need to be documentation of status by a state or local entity familiar with the child's status.
- Foster children may be included in the household application as part of the household size.
- The last four digits of the social security number for the adult signing the application needs to be listed rather than the entire social security number if the Total Household Gross Income grid is completed.

Please note that the prototype application and letter to parents/participants include the reduced price income eligibility guidelines chart. The current Income Eligibility Guidelines for determining eligibility for free or reduced price meals has been issued and is a separate document in the Online Document and Reference Library.

A flyer to be reproduced and distributed to households with information on the Child Health Insurance Program is a separate attachment. If you have any questions or need further assistance, please call Special Nutrition staff at 781-338-6480 or email nutrition@doe.mass.edu.

CHILD AND ADULT CARE FOOD PROGRAM

MEAL BENEFIT INCOME ELIGIBILITY FORM

Instructions for Child and Adult Care Food Program Centers and Sponsoring Organizations

This packet contains prototype forms:

Required information that *must* be provided to households:

- Letter to Households: Child Day Care
- Meal Benefit Income Eligibility Form: Child Day Care (with Instructions)

Additional application-related material that *must* be provided to households:

- Sharing Information With Medicaid and SCHIP

The pages are designed to be printed on 8½” by 11” paper. Some pages may be printed front and back. The **[bold bracketed fields]** indicate where you need to insert your specific contact information for assistance and where to submit the completed form(s).

This prototype package also includes information regarding the exclusion of housing allowance for those in the Military Housing Privatization Initiative and pricing programs. If these sections are not pertinent, you may remove them.

Massachusetts Department of Elementary and Secondary Education
Office for Food and Nutrition Programs
135 Santilli Highway
Everett, MA 02149





CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Dear Parent/Guardian:

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

- 1. Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: The Boys & Girls Club of Greater Westfield, Inc., 28 West Silver St., Westfield, MA 01085, (413)562-2301.**
- 2. Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) or Temporary Assistance for Families of Dependent Children (TAFDC), 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 child care center.
- 5. Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.
- 6. How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
- 7. What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
- 8. What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact : **The Boys & Girls Club of Greater Westfield, Inc., 28 West Silver St., Westfield, MA 01085, (413)562-2301.**
- 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 **413-562-2301**

Sincerely,

Kellie J. Brown
Chief Operating Office



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

If any member of the household gets SNAP or TAFDC, follow these instructions:

Part 1: List all enrolled children and household members. For any person, including children, with no income, you must check the “No Income Box”.

Part 2: List the case number for any household member receiving SNAP or TAFDC benefits.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.

Part 4: Skip this part

Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.

Part 6: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. A Social Security Number is **not** necessary.

Part 6: Answer this question if you choose to.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the “No Income Box.” Check the box if the child is a foster child.

Part 2: If the household does not have a case number, skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.

Part 4: Follow these instructions to report total household income for this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.

Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran’s (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Report income after expenses in Box 1 only if self employed. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn’t have one.

Part 6: Answer this question if you choose.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the “No Income Box.”

Part 2: Skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.

Part 4: Follow these instructions to report total household income form this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your paystub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran’s (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Report income after expenses in Box 1 only if self employed. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn’t have one.

Part 6: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):			
Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME	
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Part 2. Benefits: If any member of your household received SNAP or TAFDC cash assistance, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**
 NAME: _____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the Child Care Sponsor at Phone #: _____
 Homeless Migrant Runaway

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
<i>(Example)</i> Jane Smith	\$200/weekly _____	\$150/twice a month _____	\$100/monthly _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)
 An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the “I do not have a Social Security Number” box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____
 Date: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____
 Last four digits of Social Security Number: - - _____ I do not have a Social Security Number



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year Household size: _____

Categorical Eligibility: ____ Eligibility: Free ____ Reduced ____ Denied ____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Effective July 1, 2025 to June 30, 2026	
Household size	Yearly
1	28,953
2	39,128
3	49,303
4	59,478
5	69,653
6	79,828
7	90,003
8	100,178
Each additional person:	+10,175

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.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
- fax:**
(833) 256-1665 or (202) 690-7442; or
- email:**
program.intake@usda.gov

This institution is an equal opportunity provider



SHARING INFORMATION WITH MEDICAID/CHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get low to no cost health insurance through Medicaid or the Children's Health Insurance Program (CHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and CHIP that your children are eligible for free or reduced price meals, unless you tell us not to.** Medicaid and CHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or CHIP, fill out the form below and send it with your Income Eligibility Form to **[address]** by **[date]**. (Sending in this form will not change whether your children get free or reduced price meals.).

No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call **[name]** at **[phone]**

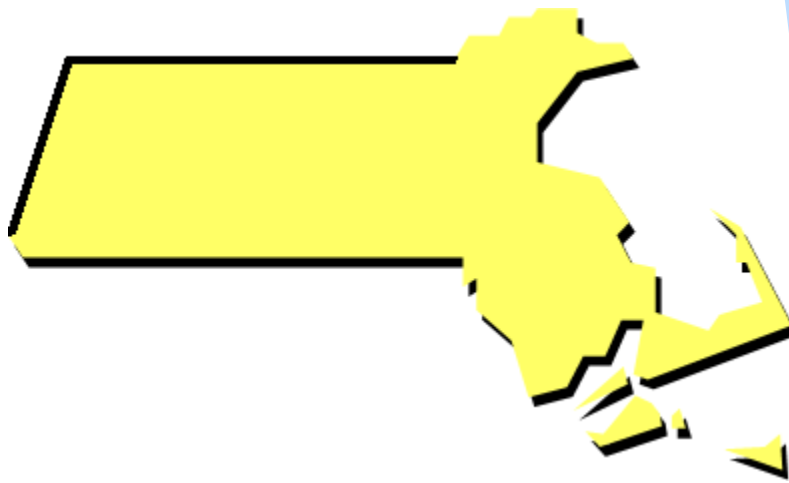


If your child is eligible for free or reduced school meals, your child may also be eligible for **free or low cost health insurance**

through MassHealth.

To learn more call: 1-800-841-2900

MassHealth



Si su niño es eligible para almuerzo gratis o reducido, su niño pueda ser eligible para **seguro de salud gratis o de bajo costo** por medio de MassHealth.

Para saber mas, llame al: 1-800-841-2900





**Massachusetts Department of Elementary and Secondary Education (DESE)
Office for Food and Nutrition Programs
Child Enrollment Documentation Requirement
Child and Adult Care Food Program – Child Care Centers**

Child Care Centers that participate in the Child and Adult Care Food Program (CACFP) are required to annually collect enrollment information from parents and guardians.

Documentation of enrollment must include:

- Each enrolled child's normal days and hours in care and the meal services in which each child normally participates
- Signature of parent or guardian
- Annual updating of the information.

7 CFR 226.15(e)(2) & 226.17(b)(7)

To document enrollment information, child care centers may use the attached CACFP Enrollment Forms or adapt their own form. An adapted form must incorporate the same questions and their intent from the DESE Child Enrollment Form. Sponsors and centers electing to revise the enrollment form must submit a copy to DESE for review and approval prior to use and distribution.

The parent/guardian must complete the form in full with current information, sign, and date the form.

Centers may not claim reimbursement for any participant without a parent/guardian signed enrollment form (new or renewal) on file. Each child enrollment form is effective for a maximum of one year.

Sponsors and centers must perform edit checks for clerical accuracy confirming data entered on all child enrollment forms.

If you have any question about the requirement for collection of enrollment information, please contact DESE Special Nutrition Services at 781-338-6480.

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(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

Child Enrollment Form

Child & Adult Care Food Program

Dear Parent/Guardian:

Your child care center **The Boys & Girls Club of Greater Westfield, Inc.** participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, the child care center has agreed to follow the USDA guidelines. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP.

In an effort to assess that these requirements are being met, the USDA and CACFP requires child care centers to annually collect the enrollment information listed below.

Please complete the form and return it to your child care center. Part 1 and Part 3 need to be completed by all families or guardians. Part 2 is to be completed ONLY if enrolling an infant child (under the age of 12 months).

PART 1: CHILD ENROLLMENT INFORMATION

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM <input checked="" type="checkbox"/> Box <input type="checkbox"/> Schedule Varies	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends <input type="checkbox"/> Sunday <input checked="" type="checkbox"/> Monday <input checked="" type="checkbox"/> Tuesday <input checked="" type="checkbox"/> Wednesday <input checked="" type="checkbox"/> Thursday <input checked="" type="checkbox"/> Friday <input type="checkbox"/> Saturday	Check the meals you request that your child receives while in care <input checked="" type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input checked="" type="checkbox"/> Lunch <input checked="" type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM <input checked="" type="checkbox"/> Box <input type="checkbox"/> Schedule Varies	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday	Check the meals you request that your child receives while in care <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
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If there are other children in care, please complete additional forms as needed.

FOR SPONSOR OFFICE USE ONLY

Effective Date of this Enrollment Form: _____ Fiscal Year _____
 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.

PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The child care center must meet the meal component requirements based on age and developmental readiness outlined in the Infant Meal Pattern. **Parents/Guardians may supply more than one required component per meal in the meal pattern (including breast milk or formula) in order for the meal to be reimbursable under the program.**

I understand that this child care center has available _____ certified formula _____ for my infant while in care.
(Name of Iron Fortified Infant Formula)

To help provide the best nutritional care for your infant, please complete the following information.

PLEASE CHECK ONE OPTION (Breast Milk / Formula):

- I will supply expressed (pumped) breast milk for my infant child and _____ fed at center. **OR** I will supply formula for my infant child.
- I prefer to have the center supply the formula offered.

PLEASE CHECK ONE OPTION (Food Items):

- I will supply all food items for my infant's meals. I do not want items provided by the provider/center.
- I have elected to have the provider/center supply the formula and I wish to provide one creditable food item. I will provide the following one creditable food item:

- I would like provider/center to provide all food items for my infant's meals.

PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form.

Parent's Signature _____

Date Signed (form must be completed annually) _____

Parent's Name: _____
: Please Print

Home Phone: _____

Mailing Address: _____

Work Phone: _____

City, State, Zip: _____

Cell Phone: _____

CIVIL RIGHTS: This information is voluntary and will not affect your children's eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.

- 1. **Ethnic Identity** HISPANIC OR LATINO NOT HISPANIC OR LATINO.
- 2. **Racial Identity** AMERICAN INDIAN OR ALASKA NATIVE ASIAN BLACK OR AFRICAN AMERICAN
 NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER WHITE.

For questions please contact: Sponsor or Child Care Center, Contact Name, Address, and Telephone Number

**The Boys & Girls Club of Greater Westfield, Inc.,
28 West Silver St., Westfield, MA 01085
413-562-2301**



CLOSURES FOR 2025-2026

Holiday/Flexible Day	Month/Day/Year
Friday Before Memorial Day	Friday May 22, 2026
Memorial Day	Monday May 25, 2026
Professional Development Day	Thursday June 18, 2026
Juneteenth Day	Friday June 19, 2026
Professional Development Day	Monday June 22, 2026
July Fourth observance	Friday July 3, 2026
Professional Development Day	Thursday August 27, 2026
Professional Development Day	Friday August 28, 2026
LAST DAY FOR SCHOOL YEAR 2026	WEDNESDAY JUNE 17, 2026
FIRST DAY OF SUMMER PROGRAMMING 2026	TUESDAY JUNE 23, 2026
UPDATED 4-3-2026	

There will be no charge to families on the above dates.

ALL STAFF ARE REQUIRED TO WORK PROFESSIONAL DEVELOPMENT DATES

ANY QUESTIONS PLEASE FEEL FREE TO CONTACT KELLIE BROWN, CHIEF OPERATING OFFICER

[**KBROWN@BGCWESTFIELD.ORG**](mailto:KBROWN@BGCWESTFIELD.ORG)



CLOSURES FOR 2026-2027

Friday July 3, 2026 (Independence Day)	Club Closed
Thursday August 27, 2026	Staff Professional Dev./Club Closed FOR CHILDREN
Friday August 28, 2026	Staff Professional Dev./Club Closed FOR CHILDREN
Monday Sept. 7, 2026 (Labor Day)	Club Closed
Monday October 12, 2026 (Indigenous Day)	Club Closed
Thursday November 26, 2026(Thanksgiving)	Club Closed
Friday November 27, 2026	Club Closed
December 24 & 25, 2026	Club Closed
December 31, 2026, January 1, 2027	Club Closed
Monday January 18, 2027 (MLK Day)	Staff Professional Dev./Club Closed FOR CHILDREN
Friday May 28, 2027	Club Closed
Monday May 31, 2027 (Memorial Day)	Club Closed
Friday June 18, 2027 (Juneteenth Day)	Club Closed

We will be closed 2 days for summer 2027 PROFESSIONAL DEVELOPMENT

in June those dates are TBD pending Westfield Public Schools last day for 2027

There will be no charge to families on the above dates.

ALL STAFF ARE REQUIRED TO WORK PROFESSIONAL DEVELOPMENT DATES

ANY QUESTIONS PLEASE FEEL FREE TO CONTACT:

KELLIE BROWN, CHIEF OPERATING OFFICER /LICENSEE

kbrown@bgcwestfield.org

Closures updated 5/7/2026