Bright Start Learning Center

316 N. Main Street
Johnstown, OH 43031
Phone: 740-967-8454 * Fax: 740-967-2748

Dear Parents,

We are pleased that you are interested in Bright Start Learning Center. We are committed to providing your family the best possible care during the most formative years of your child's life.

The center is privately owned and operated as a local Johnstown Daycare and is licensed by the Ohio Department of Job and Family Services and approved to provide Childcare service. We provide care and learning opportunities for children age six weeks thru the 5th grade of school from 6:00 a.m. to 6:00 p.m. Monday thru Friday.

Our first and foremost goal is to provide a caring and nurturing environment that is sensitive to the needs of young children. Using age appropriate curriculum and activities we provide learning experiences that build progressively as your child continues to grow and acquire new concepts and skills.

Our Director, Lacey provides daily management of our Center and she will be working with you thru the enrollment process and will also assist with any future needs. We believe that Lacey and our teaching staff will do their best to make your family feel welcome. We know they all look forward to getting acquainted with your child.

Barry & Debbie Hines,

Owners

Bright Start Learning Center

New Student Application Packet

316 N. Main Street
Johnstown, OH 43031
Phone: 740-967-8454 * Fax: 740-967-2748

What's Next? The Application and Enrollment Process

Please complete all applicable forms in this packet for **each** child who will be enrolled in our center. The forms must be filled in completely leaving no empty spaces.

Enrollment Forms Checklist (All Students)

_____ Child Enrollment and Health Information (3 pages)

_____ Child and Family Information (2 pages)

_____ Schedules, Tuition and Financial Obligations

_____ General Permission Form

_____ Licking County Child Enrollment form for Publicly Funded Childcare - only required for families applying for assistance from Job & Family Services (JFS) for their tuition

_____ Food Program Enrollment (information page + enrollment form)

_____ Food Program Income Eligibility Application (optional form, but necessary to the daycare if you are receiving food assistance thru SNAP, OWF or receiving Tuition Assistance thru JFS)

Additional Forms: Required as stated for Infant and Preschool children

_____ Child Medical Statement – **Infant, Toddler and Preschool children only**. Shot record is required prior to first day of attendance; physical by Physician required within 30 days

_____ Infant Only Packet – This packet provides us with all the details on feeding, diaper changes, etc.

Final Step

Meet with our Director! Return your forms and enrollment fee to our center office. Our Director will review your forms, complete your tuition information sheet and establish your child's first date of attendance.

Other Important Notes Regarding Enrollment

Building Access - You will use a 4-digit access code to enter the building to drop off and pick up your child. Please provide this number on the Child and Family Information Form in the space designated.

Communication by E-mail – Please provide current e-mail addresses on the Child and Family Information form as we will use this means to communicate with you about closings, special events and other important information.

Parent Participation – Parents are welcome to observe or volunteer in the classroom. Parent-Teacher conferences will be scheduled upon request by either the parent or teacher.

Parent Handbook – A parent handbook is available on our website for your review at www.brightstart-lc.com. Please read and review at your leisure,

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

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

If you answered yes, please indicate which number(s) 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		Relationship to Child
Home Address		Home Telephone Number
City	State / Zip	
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

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

If you answered yes, please indicate which number(s) 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 within one hour of the center/home, 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 Food Supplements

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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care 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, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

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.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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 _____ 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			**_Do Not Give Permission_ to Transport**	
Program or Home Name			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.		**OR** **Do not sign both**	**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 and 5101:2-13-15. 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.

Bright Start Learning Center

Child and Family Information

316 N. Main Street
Johnstown, OH 43031
Phone: 740-967-8454 * Fax: 740-967-2748

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in our care.

Tell Us About Your Child

Full Name _____
Nickname (if any) _____ M/F _____ Ethnicity _____
Birthdate _____ Child's Age _____ School Grade (if app) _____

Has your child had a previous care arrangement? Yes _____ No _____ Additional details? (center based, in home, with family, with parents, or any other pertinent info) _____
_____

List things your child might be anxious about as he/she starts in this program? _____

Please check all the words that best describe your child's personality and behavior
___ active ___ adventurous ___ affectionate ___ anxious ___ bossy ___ calm ___ cautious ___ cheerful
___ content ___ creative ___ curious ___ easily angered ___ emotional ___ energetic ___ excitable
___ friendly ___ gives-in easily ___ happy ___ hesitant ___ insecure ___ jealous ___ likes routine
___ loud ___ mellow ___ outgoing ___ prefers adult attention ___ quiet ___ sensitive ___ shares well
___ social ___ spontaneous ___ stubborn ___ tentative ___ other: _____

What are some of your child's favorites?
Food(s) _____
Movie/TV show Character _____
Inside activity _____
Outside activity _____
Other _____

Does your child/family have a pet? What kind? Name? _____

Are there any special sleep / nap habits? _____

Are there things that frighten your child? _____

Are there things that cause your child to feel angry or frustrated? _____

What do you do to comfort your child in either of these situations? _____

Is there anything else we need to know about your child to ensure he or she makes a smooth transition to our center and can be well cared for by our staff?

_____

_____

Tell Us About You and Your Child's Family

1 - Parent/Guardian's Name _____ Relationship to Child _____
Best Daytime Phone: _____ Type: _____ Work _____ Cell _____ Home
E-mail address _____

2 - Parent/Guardian's Name _____ Relationship to Child _____
Best Daytime Phone: _____ Type: _____ Work _____ Cell _____ Home
E-mail address _____

Who does the child live with? (Please Circle)

Mother	Stepmother	Grandma	Foster Parent	Other _____
Father	Stepfather	Grandpa	Legal Guardian	

Siblings @ home _____ brothers and _____ sisters. Their names and ages are:
_____

Are there any special family arrangements such as shared parenting, custody specifications, etc. that will be applicable while in our care? Yes _____ No _____ If yes, please explain _____

My child has regular contact with these people who help provide care when needed:
(grandparents, stepparents, other family member, family friend)
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

What is the primary language spoken in your child's home? _____

General Information

How did you hear about our Childcare Center? (Please circle)
Drive by Online Referred by _____ Other (specify)_____

My Preferred start date would be _____

My requested code for Building Access for drop off and pick up of children (4 digits) _____

Parent/Guardian Signature _____ Date _____

Bright Start Learning Center

Schedules, Tuition & Financial Obligations

Child's Name _____ Age _____ School Grade _____

Center Schedules

Center hours: 6 am to 6:00 pm, Mon – Fri.

Center Closings: *Note: Tuition/Family Fee is not reduced due to center closures.*

Holidays: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving (& day after), Christmas Eve and Christmas Day.

Professional Development: We dedicate 2 days/year for professional development for our staff. Advance notification is provided.

Severe Weather or Other Emergency: Example - When determined unsafe for travel or extended power outage

Attendance Schedule Options (please circle desired choice)

4/5 days per week 3 days per week 2 days per week

Daily Drop off Schedule (Time)

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____

Daily Pick Up Schedule (Time)

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____

Priority Enrollment is given to 4/5 day students. We will accommodate part-time 2 or 3 day students as space allows. Maximum hours of service are 50 hours / week.

My Tuition and Fee Information (Director to complete - Please refer to our Rate Schedule for specific tuition information)

Registration Fee	Weekly Tuition/Fee	Transportation	Total Tuition	Tuition Payment Pref
$50 $100				We Bi Mo

Note: Families applying for state assistance must provide proof of submitted paperwork prior to first day of attendance

Tuition & Schedule Obligations

- I understand my first tuition payment will be due on my child's first day of attendance
- Tuition is due weekly in advance for your childcare services. Options are available for bi-weekly or monthly payment plans with prior arrangements with our Director
- Child's schedule changes –Notify the center office of any changes ASAP
- Additional Days Services – May be available but based on classroom availability - additional charges apply
- School age children – Service is available on no school days/snow days – additional charges may apply
- I agree to pay the full tuition even if my child is absent, except for pre-arranged "vacation weeks."
  Vacation Week Guidelines: If you know your child will be absent for a **full week**, you may use a vacation week. There is no charge for this vacation week if advance notice is given. Your notice allows us to adjust staffing if appropriate. Our center offers a maximum of 3 vacation weeks per calendar year.

I have read the above information and agree to all schedule and tuition guidelines.

Parent/Guardian Signature _____ Date _____

Director Signature _____ Date _____

Office Use Only: Date Reg. Fee Paid: _____ Check #: _____ Classroom Assignment: _____

Bright Start Learning Center

Authorized Pick Up List

This form must be updated annually

Child's Name _____

Authorized Pick up List

The safety of children in our center is our top priority. Center staff will release your child only to individuals you have authorized. Please list below the names of individuals **besides the parents/guardians** *who are authorized to pick up your child. Please note, ID may be requested to verify identity.*

Name	Phone	Relationship
1		
2		
3		
4		

Bright Start Learning Center

General Permission Form

This form must be updated annually

Child's Name _____

Walks Permission

At various times throughout the year our children take short walks in proximity around the center, to the Library, or to nearby parks. Please sign below and return this form to the office. Written permission shall be considered valid for all routine trips until withdrawn in writing by the parent/guardian.

_____ Yes, my child may participate in these walks

_____ No, my child may not participate in these walks

Parent/Guardian Signature _____ Date _____

Bus Transportation Permission (school age children)

We provide transportation to and from school for students who attend Johnstown Elementary and Alexandria Elementary Schools by means of a BSLC bus or van for a small fee. I give permission to BSLC to transport my child to and from school. Written permission shall be considered valid for all trips to/from school until withdrawn in writing by the parent/guardian.

My Child's school is _____

Parent/Guardian Signature _____ Date _____

Licking County
Job & Family Services
Help for today. Hope for tomorrow.

p: 740-670-8999 / f: 740-670-8992
74 S. 2nd Street / P.O. Box 5030
Newark, Ohio 43058-5030
LickingCountyJFS@jfs.ohio.gov

NOTICE OF CHILD ENROLLMENT
FOR PUBLICLY FUNDED CHILD CARE (PFCC) SERVICES

Caretaker's Name	Caretaker's SS Number	Case Number

Provider's Name	Provider's ID/License Number

OAC 5101:2-16-55 (D)

If a provider receives a JFS 01140 (Temporary Voucher for Publicly Funded Child Care Services) from an eligible caretaker, the provider shall contact the County Department of Job & Family Services that issued the JFS 01140 to confirm child enrollment and the start date of child care services.

Child(ren)'s Name	Requested Start Date	Requested Hours

Is the child(ren) enrolled with another child care provider? _____

If yes, who is the provider? _____ Number of Hours Enrolled _____

Caretaker's Signature _____ Date _____

Provider's Signature _____ Date _____

Annette Shroyer for caretakers with last names A-J
Erin Conners for caretakers with last names K-S
Haley Foreman for caretakers with last names T-Z

Fax: 740-670-8992

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups)
Milk Fruit or Vegetable Grain Meat/meat alternate (may be substituted for the grain up to 3 times per week)	Milk Meat/meat alternate Grain Vegetable (two different vegetables can be substituted for a fruit) Fruit	Milk Meat/meat alternate Grain Vegetable Fruit

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed private homes.
- **After School Care Programs**: Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Bright Start Learning Center
316 N. Main Street
Johnstown, OH 43031
Phone - 740-967-8454

Ohio Department of Education

CACFP Program Specialist
25 S. Front Street, MS 303
Columbus, OH 43215-4183
Phone: 614-466-2945
Toll Free: 1-800-808-6235

Nondiscrimination

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
(2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

10/2017

Ohio Department of Education - Office of Integrated Student Supports

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**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

(2) fax: (202) 690-7442; or

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

This institution is an equal opportunity provider.

Revised 10/2019

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2020-2021

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* adult 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	Bright Start Learning Center

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)
1.			☐
2.			☐
3.			☐
4.			☐

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.

Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)

CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _
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: 7/1/2020

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.

HOUSEHOLD LETTER - Dear Parent or Guardian

Please help us comply with the requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. **The completion of the income eligibility application is optional.** Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits. An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced-price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (*denotes required info)

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.

PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.

a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

b) Check the box for any person listed as a household member (including children) that has no income.

c) For each household member, list each type of income received during the last month and list how often the money was received.

1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and 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.
2. List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

a) * All applications must have the signature of an adult household member.

b) * The adult signing the application must also date the form.

c) * Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

NON-DISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

REDUCED INCOME ELIGIBILITY GUIDELINES
Guidelines to be effective from July 1, 2020 through June 30, 2021
Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add	+8,288	+691	+346	+319	+160

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

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

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional

Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		