



## Enrollment Packet

Thanks for your interest in Growing Kids Learning Centers. The Enrollment Process is as easy as...

- 1) Complete the Enrollment forms  
Bring them with you when you tour or before your child's first day.
  
- 2) Call or Meet with the Center Director to coordinate an enrollment opening and schedule a start date.  
Availability is limited and changes frequently. Children are enrolled on an as-available basis.

This Packet Includes the following forms to complete:

- o Tuition Agreement
- o Enrollment Form
- o Authorized Pick Up List & Emergency Contacts
- o Parent Questionnaire
- o Verification of Age and Consent to Report
- o Health Record (must be completed within 30 days of enrollment)
- o USDA/CACFP Food Program (for all families)

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Preferred Start Date: \_\_\_\_\_

**Thank you for choosing Growing Kids Learning Center.**



# Tuition Agreement

<b>Programs Available</b> (Please circle one. Ask the Director if more options are needed.)			
Infant Care (6 weeks – Walking)	5 Full Days (7:00 am - 6:00 pm)		
Toddler Care (Walking - 24 Months)	5 Full Days		
Young Preschool (24mo. - 3 years)	5 Full Days	5 Half Days	3 Full Days
Preschool (3 yrs & Potty Trained - 5 years)	5 Full Days	5 Half Days	3 Full Days
Kindergarten (5 yrs. by September 1)	5 Full Days	5 Half Days	
After School Care (Elem. Grades)	5 Days	Additional charges apply for extra ½ and full days.	
Evening Care (2 yrs and older)	Care available until 11:30 p.m. weekly or as needed. <b>Prior sign-up required.</b>		

For the Program Selected,  
Your Weekly Tuition Rate Is:

\$\_\_\_\_\_ If Paid In FULL on  
Monday with **PrePay**  
**Discount**

\$\_\_\_\_\_ Regular Tuition Rate  
(no PrePay Discount)

This amount can change if  
your child's program changes.

### Payments and Due Dates

All Payments are due in advance weekly on Mon. morning.  
Advanced payments are accepted.  
All payments are non-refundable.  
The annual registration fee of \$50 is charged upon enrollment and every August thereafter.  
A Service fee of \$25 is charged for all returned checks.  
Non-Payment of Tuition can terminate enrollment.  
Forms of payment accepted: Debit Cards, Checks, Visa / MasterCard, AutoPay from Checking.

**Parent(s) signing below are responsible for paying any balance due, including any balances remaining after payments from childcare voucher, 3<sup>rd</sup> party reimbursement, or other outside source.**

### Late Pick Up Fees

A fee of \$5 is charged for every 15 minutes a child is picked up after the scheduled pick-up time. Payment is due immediately. See the Parent Handbook for more info.

### Holiday Schedule

The center will be closed on the following holidays (or closest weekday). The regular tuition is still due these weeks. Evening Care schedule may be adjusted as well.

- New Year's Day                      - Memorial Day - July 4<sup>th</sup>
- Labor Day                              - Thanksgiving - Christmas Day

### Schedule or Program Changes

If your child's schedule or program changes, your tuition will change accordingly. To request a schedule change, please notify the director in writing.

To qualify for the PrePayment Discount, your balance must be paid in full by Monday of each week.

Your tuition is due in full each week regardless of illness or other absence. The center does provide 2 weeks "Vacation" per calendar year where tuition is waived when your child does not attend. Vacation requests should be in writing -- Please see the Parent Handbook for details. Overdue accounts will be charged a service fee. The parent understands that he/she assumes all responsibility for interest charges, collection agency, legal or court fees associated with the collection of this account, if that becomes necessary. Parents electing to withdraw their child must provide two weeks written notice to the center. Any issue under this agreement or relating to the service provided shall be subject to mediation and, if not resolved by mediation, arbitration under the rules of the American Arbitration Association.

Child: \_\_\_\_\_

Parents' Signatures: \_\_\_\_\_

Date: \_\_\_\_\_

Director: \_\_\_\_\_

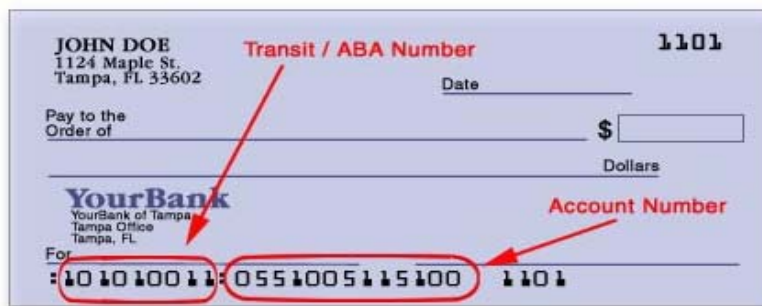
Thank you for agreeing to pay your bill using Automatic Payment. Electronic payment is a time saver for us and I trust you will find the convenience equally as satisfying. Banking rules require that you give your approval to pay your bill in this way. The approval is active until you notify us that you want to stop using Automatic Payment.

Automatic Payment is safe, efficient, and consumer friendly. Banking law protects consumers from ever having to worry about someone taking money from their account using Automatic Payment in an unauthorized manner.

Please complete this form and return it to us so we can get you set up for Automatic Payment.

<b>DIRECT PAYMENT AUTHORIZATION</b>			
I hereby authorize _____ to initiate entries to my checking or savings account at the financial institution listed below. This authority will remain in effect until five days after I provide written notice to cancel it.			
_____ Your Name <i>(please print)</i>		_____ Bank or Credit Union Name	
_____ Your Address		_____ Bank or Credit Union Address	
_____ City	_____ State	_____ Zip	_____ City
_____ <b>Account Number</b> <i>(see sample below)</i>		_____ <b>Transit / ABA Number</b> <i>(see sample below)</i>	
_____ Your Signature		_____ Today's Date	
<i>(Please attach a copy of or a void check- deposit slips don't work)</i>			

*Sample Check*



<b>For Office Use Only</b>	
<b>Center:</b>	<b>Child's Name:</b>
<b>Tuition:</b>	<b>ReliaFund Start Date:</b>



**Student Information**

Name: \_\_\_\_\_  
 Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
 Child Lives With: \_\_\_ Mother \_\_\_ Father  
 \_\_\_ Other: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_\_\_

Start of Care: \_\_\_/\_\_\_/\_\_\_\_\_

Gender: \_\_\_ Boy \_\_\_ Girl

Parents are: \_\_\_ Married \_\_\_ Single

\_\_\_ Other \_\_\_\_\_

In the chart below, please indicate the normal **days and hours** your child is in care, and the **meals received** while in care.

	MON	TUE	WED	THUR	FRI
Please enter the normal hours your child is in care (e.g. 7:30 – 5:30pm)					
Please check (✓) the meals your child normally receives while in care	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack	<input type="checkbox"/> AM Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Afternoon Snack <input type="checkbox"/> Dinner <input type="checkbox"/> Evening Snack

This information is required by CACFP federal regulations at §226.15(e)(2) and (3) for each enrolled child and must be updated **annually**.

- Check if your child's schedule may vary
- Check if your school aged child might attend before/after school care and school holidays during the school year.

**Parent (Guardian) Information**

	<b>First Parent</b>	<b>Second Parent</b>
Relationship	___ Mother ___ Father	___ Mother ___ Father
Name:	_____	_____
Home Address:	_____	_____
City/State/Zip Code:	_____	_____
Home Phone:	_____	_____
Employer Name:	_____	_____
Employer Address:	_____	_____
City/State/Zip Code:	_____	_____
Employer Phone:	_____	_____
Work Hours:	_____	_____
Soc.Sec.# / D.L.:	_____	_____
Email Address:	_____	_____



**Authorization and Consent**

I/We state that we are the legal parent/guardian of the minor child listed below.

Please Initial

\_\_\_\_\_ **Authorization for Medical Treatment of a Minor** – I authorize, for emergency purposes only, Growing Kids Learning Center to consent to any necessary examination, medical diagnosis, surgery or treatment, and / or hospital care to be rendered to the minor child listed below, under the general or special supervision and on the advice of any physician licensed to practice in the state of Indiana.

\_\_\_\_\_ **Liability Release for Services Provided Outside of Growing Kids Learning Center** – I release and hold harmless Growing Kids Learning Center, its owners, and its employees from any liability or accident that may occur should I retain the services of any Growing Kids employee for services **outside** the learning center. I also agree not to solicit Growing Kids employees away from the learning center for alternate employment opportunities.

\_\_\_\_\_ **Photo Release** – Growing Kids, its affiliates and agents, may use photographs, reproductions, images, and sound recordings of my child for advertising, publicity, or other lawful use.

\_\_\_\_\_ **Authorized Pick Up** - Children will be released only to a parent or a person named by the parent. Parents or persons named by the parent must make sure that a staff member is aware of the child’s arrival and departure. Parents shall sign the child in and out by name and time of arrival and departure. Parents cannot share access codes, computer passwords, and other security measures with unauthorized people.

\_\_\_\_\_ **Receipt of Growing Kids Parent Handbook** – I have read and understand the Growing Kids Parent Handbook that was given to me upon enrollment.

\_\_\_\_\_ **Agreement to Pay Tuition** – I have read and signed a Tuition Agreement form that specifies the tuition amount and the frequency of payments to Growing Kids for services rendered.

Name of Child: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Thank You for Choosing Growing Kids Learning Center**

We are dedicated to providing the highest quality child care. Please feel free to speak with your child’s teacher or the center director regarding any question or concern you may have. We welcome your comments and involvement in the center.

Office Use Only –	Center:
Enrollment Offer Date:	Expected Start Date:
Enrollment Offered by:	Offer Expiration Date:
Classroom / Schedule:	



# Authorized Pick Up List & Emergency Contact List

This form designates what adults are able to pick-up your child from the Growing Kids Learning Center and what adults to contact in the event of an emergency. Please list the adults in the order you would like us to contact them in the event of an emergency or, more likely, a student illness.

Student Name: \_\_\_\_\_

Computer Password: \_\_\_\_\_

Home Address: \_\_\_\_\_

Contact Order	Name	Relationship	Phone Number		
1	Mother or Father		Home: _____	Work: _____	Cell: _____
2	Mother or Father		Home: _____	Work: _____	Cell: _____
3			Home: _____	Work: _____	Cell: _____
4			Home: _____	Work: _____	Cell: _____
5			Home: _____	Work: _____	Cell: _____
6			Home: _____	Work: _____	Cell: _____

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Allergies or Other Restrictions: \_\_\_\_\_

Pick Up Restrictions (legal documentation generally required): \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**A copy of this form to accompany the child on all field trips.**



**Child Information**

Child's Full Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_  
Name Child is Called \_\_\_\_\_ (circle gender) Male Female

**Please Fill Out the Following Information**

List all persons living in the household

Name	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe child's previous child care experience  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental History**

Type of Birth Normal Premature Complications \_\_\_\_\_

Languages spoken in the home \_\_\_\_\_ Primary Language \_\_\_\_\_

Any difficulties in speaking? \_\_\_\_\_ If yes, explain \_\_\_\_\_

**Circle if child can:**

Crawl Walk (more than 5 steps on own) Put on shoe Button  
Tie shoe Buckle Zip zipper Dress self Feed self

Explain any difficulties in physical development \_\_\_\_\_

**Toilet Training (circle)**

Child is in a Diaper Pull-up Training Pant Underwear  
Child is successful on the toilet Always Urine BM  
Child stays dry All Day Through Nap Through Night  
Child will go to toilet By Self When Asked

**Sleep Habits**

When is child's bedtime? \_\_\_\_\_ When does he awaken? \_\_\_\_\_ Does he/she share a room? \_\_\_\_\_  
With whom? \_\_\_\_\_ Own bed? \_\_\_\_\_ Shared with whom? \_\_\_\_\_  
What is child's general mood upon awakening? \_\_\_\_\_  
Nap Schedule \_\_\_\_\_



**Eating Habits**

Favorite foods \_\_\_\_\_

Foods disliked \_\_\_\_\_

List any foods child can not eat (Must have a Doctor's note) \_\_\_\_\_

Is child on (circle)      Breast Milk      Formula      2% milk      Other \_\_\_\_\_

Does child drink from a bottle? \_\_\_\_\_ Use a sippie cup? \_\_\_\_\_ Open cup? \_\_\_\_\_

Eat table food? \_\_\_\_\_ Use a pacifier? \_\_\_\_\_ Suck Thumb? \_\_\_\_\_

**\* Parents of infants must complete the enclosed *Feeding Plan* and have it signed by child's doctor.**

**Social and Emotional Behavior/Experience**

Does child have temper tantrums? \_\_\_\_\_ Explain \_\_\_\_\_

Does child pick up toys after playing? \_\_\_\_\_

With what age group does child usually play? \_\_\_\_\_ Favorite Toy? \_\_\_\_\_

How does child relate to new people? \_\_\_\_\_

What upsets your child? \_\_\_\_\_

What makes child happy? \_\_\_\_\_

How does child demonstrate anger? \_\_\_\_\_

How do you discipline at home? \_\_\_\_\_

How best would you describe your child's disposition? \_\_\_\_\_

Child is frightened by (circle)

Animals      Loud noises      Sirens      Darkness      Water      Other \_\_\_\_\_

Concerns or Comments?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent Signature

Date

Parent Signature

Date



# Verification of Age and Consent to Report

Pursuant to Indiana law, Growing Kids must verify each child's birth date. As part of that law, we must also report the names of the children that enroll or withdraw from the center.

**1. Proof of Age** – Required of all children.

Please present to the Growing Kids office a documented copy of your child's birth certificate or any other documentable record. We only have to see it and make a copy. We will not keep the original.

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**2. Consent -** Please choose whether or not to provide permission for the center to include your child's name in the enrollment report to the Division of Family and Children. While the center is required by law to submit the report, participation is voluntary for parents.

***Please Choose One***

**Yes, I give my permission** for Growing Kids to report the name and birth date of my child to the Division of Family and Children, pursuant to IC 12-17.2-2-1.5

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**No, I do not give my permission** for Growing Kids to report the name and birth date of my child to the Division of Family and Children, pursuant to IC 12-17.2-2-1.5

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**For Office Use Only** -----

Proof of Birth Date Provided:                      Yes                      No

Copy Put in Child's File                              Yes                      No

Completed by: \_\_\_\_\_  
Staff Member / Date



# Child Care Center Health Record

Child's Name (last, first)		Date of Birth	Admission Date
Address			
Child lives with (relationship)	Name		Telephone Number

Medical History		
Communicable Disease	Month / Year	Condition / Explain if Present
Measles		Allergies:
Rubella (German Measles)		
Chicken Pox		Handicapping Conditions:
Mumps		
Scarlet Fever		Other:
Whooping Cough		
Hepatitis B		
Other: _____		

Physical Examination	
Date of Exam:	Age of child:
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:
Note any unusual findings:	
<p>Does this child have any health condition that would be hazardous to the child or to other children in a group setting as a result of participation in normal activities (including sports)? If yes, what modifications of normal activities would be necessary to protect the child and the child's classmates?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	
<p>Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> NO</p>	

(Over)



**History of Immunizations and Tests** (*indicate month/day/year*)

	1	2	3	4	5
DTP/DT/Td					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV					

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

	1	2	3	4
Pneumococcal (PCV)				

	1	2	3
HBV			

Note: To be considered adequately immunized, a child of age 24 months should have received four DTP inoculations, three polio inoculations, one inoculation against measles, mumps, and rubella, and at least 3 Hib vaccinations.

Name of physician completing form (please print)	Telephone Number
Signature of physician	

<b>Additional Notes and Instructions</b>
<hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/>



# Help Us Provide Better Meals and Snacks!

We need EVERY FAMILY to complete the attached form  
and return it to the office NOW!\*

It only takes a few minutes.

To provide higher quality meals and snacks for the children at the center, this center participates in the US Department of Agriculture's CACFP food program.

For every family enrolled, the center receives some reimbursement from the food program. The center receives *higher* reimbursement when more families properly complete this form.

The funds the center receives from the food program enable us to provide higher quality meals and snacks to the kids at no additional cost to the parents. It is basically an extra source of funds (besides parent tuition).

If you have any questions, please ask. We would be happy to help.

Thanks

\*Why NOW? Because if you take it home, it probably won't come back for awhile...  
We understand. Life gets pretty busy.

## Growing Kids Learning Center on Bristol St

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Growing Kids** 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 Application for Free and Reduced Price Meals. 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 Bristol St location.**
- 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 Needy Families (TANF) 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 the 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 all people in your household (such as grandparents, other relatives, or friends who live with you). 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 or TANF 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 **Growing Kids at (574)266-1800.**
- 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 **(574)266-1800.**

Sincerely,

**Heather Miller**

The United States Department of Agriculture has issued the following income guidelines  
effective **July 1, 2011 - June 30, 2012**

Household Size	Reduced-Price Meals – 185%					Free Meals – 130%				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	20,147	1,679	840	775	388	14,157	1,180	590	545	273
2	27,214	2,268	1,134	1,047	524	19,123	1,594	797	736	368
3	34,281	2,857	1,429	1,319	660	24,089	2,008	1,004	927	464
4	41,348	3,446	1,723	1,591	796	29,055	2,422	1,211	1,118	559
5	48,415	4,035	2,018	1,863	932	34,021	2,836	1,418	1,309	655
6	55,482	4,624	2,312	2,134	1,067	38,987	3,249	1,625	1,500	750
7	62,549	5,213	2,607	2,406	1,203	43,953	3,663	1,832	1,691	846
8	69,616	5,802	2,901	2,678	1,339	48,919	4,077	2,039	1,882	941
For each add'l family member, add	7,067	589	295	272	136	4,966	414	207	191	96

THE TOTAL HOUSEHOLD INCOME STATED ON THE ENROLLED CHILDREN'S INCOME APPLICATION MUST BE COMPARED TO THE ABOVE GUIDELINES PRIOR TO THE SUBMISSION OF THE JULY CLAIM FOR REIMBURSEMENT FOR THE CURRENT FISCAL YEAR.

Following is the definition of income:

"Income" as the term is used in this notice means income before any deductions such as income taxes, social security taxes, insurance premiums, charitable contributions, and bonds. It includes the following: (1) Monetary compensations for services, including wages, salary, commissions, or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security; (5) dividends or interest on savings or bonds or income from estates or trusts; (6) net rental income; (7) public assistance or welfare payments; (8) unemployment compensation; (9) government civilian employee or military retirement, or pensions or veterans payments; (10) private pensions or annuities; (11) alimony or child support payments; (12) regular contributions from persons not living in the household; (13) net royalties; and (14) other cash income. Other cash income would include cash amounts received or withdrawn from any source including savings, investments, trust accounts, and other resources which would be available to pay the price of child's meal.

"Income" as the term is used in this notice, does not include any income or benefits received under any Federal programs that are excluded from consideration as income by legislative prohibition. Furthermore, the value of meals or milk to children shall not be considered as income to their households for other benefit programs due to prohibitions in section 12(e) of the National School Lunch Act and section 11(b) of the Child Nutrition Act of 1966(42 U.S.C. 1760(e) and 1780(b)).

If you have any questions, please contact Carol Markle ([cmarkle@doe.in.gov](mailto:cmarkle@doe.in.gov) or 317-232-0873) or Maggie Abplanalp ([maggie@doe.in.gov](mailto:maggie@doe.in.gov) or 317-232-0851) or 800-537-1142 (ext. 20873 or ext. 20851).

## CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

<b>SPONSOR NAME: GK BRISTOL CHILDCARE CORP</b>	<b>PHONE NUMBER: (574) 266-1800</b>
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<b>CENTER: BRISTOL ST</b>	<b>FDC PROVIDER:</b>
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<b><u>PART 1. ALL HOUSEHOLD MEMBERS</u></b>	BIRTH DATES OF CHILDREN	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 4 TO SIGN THIS FORM.	CHECK IF NO INCOME
NAMES OF ALL HOUSEHOLD (FIRST, MIDDLE INITIAL, LAST)			
		<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"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**PART 2. BENEFITS:** IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVED FOOD STAMPS] OR [STATE TANF 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 [BRISTOL ST AT (574)266-1800]      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) <i>(EXAMPLE)</i> JANE SMITH	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
	\$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: XXX - XX - \_\_\_\_\_  I DO NOT HAVE A SOCIAL SECURITY NUMBER

## CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

A CHILD ENROLLED IN THE DAY CARE FACILITY MAY QUALIFY FOR FREE OR REDUCED PRICE MEALS IF THE HOUSEHOLD INCOME FALLS AT OR BELOW THE LIMITS ON THIS CHART:

JULY 1, 2011 TO JUNE 30, 2012			
HOUSEHOLD SIZE	MONTHLY INCOME	HOUSEHOLD SIZE	MONTHLY INCOME
1	1,679	5	4,035
2	2,268	6	4,624
3	2,857	7	5,213
4	3,446	8	5,802
FOR EACH ADDITIONAL FAMILY MEMBER, ADD \$589			

PART 6. PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)	
MARK ONE ETHNIC IDENTITY: <input type="checkbox"/> HISPANIC OR LATINO  <input type="checkbox"/> NOT HISPANIC OR LATINO	MARK ONE OR MORE RACIAL IDENTITIES: <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN

<b>PART 7: OTHER BENEFITS:</b> THE LAW ALLOWS US TO TELL MEDICAID AND HOOSIER HEALTHWISE THAT YOUR CHILDREN ARE ELIGIBLE FOR FREE OR REDUCED-PRICE MEALS. WE MAY SHARE YOUR APPLICATION INFORMATION WITH MEDICAID OR HOOSIER HEALTHWISE UNLESS YOU DO NOT WANT US TO. IF YOU DO NOT WANT US TO SHARE THIS INFORMATION, SIGN HERE:	
_____ SIGNATURE OF PARENT OR LEGAL GUARDIAN	FOR INFORMATION ABOUT HOOSIER HEALTHWISE HEALTH INSURANCE CALL <b>1-800-889-9949</b>

**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.

**NON-DISCRIMINATION STATEMENT:** THIS EXPLAINS WHAT TO DO IF YOU BELIEVE YOU HAVE BEEN TREATED UNFAIRLY. "IN ACCORDANCE WITH FEDERAL LAW AND U.S. DEPARTMENT OF AGRICULTURE POLICY, THIS INSTITUTION IS PROHIBITED FROM DISCRIMINATING ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, OR DISABILITY. TO FILE A COMPLAINT OF DISCRIMINATION, WRITE USDA, DIRECTOR, OFFICE OF ADJUDICATION, 1400 INDEPENDENCE AVENUE, SW, WASHINGTON, D.C. 20250-9410 OR CALL TOLL FREE (866) 632-9992 (VOICE). INDIVIDUALS WHO ARE HEARING IMPAIRED OR HAVE SPEECH DISABILITIES MAY CONTACT USDA THROUGH THE FEDERAL RELAY SERVICE AT (800) 877-8339; OR (800) 845-6136 (SPANISH). USDA AND THE STATE OF INDIANA ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS."

CHILD CARE REPRESENTATIVE USE ONLY	
ANNUAL INCOME CONVERSION: <u>WEEKLY X 52</u> – <u>EVERY 2 WEEKS X 26</u> – <u>TWICE A MONTH X 24</u> – <u>MONTHLY X 12</u>	
<b>SECTION A</b> MARK ONE OF THE BOXES BELOW TO SHOW HOW YOU ARE GOING TO DETERMINE ELIGIBILITY.  <input type="checkbox"/> <b>FOOD STAMP OR TANF HOUSEHOLD</b> —THE FOOD STAMP OR TANF NUMBER MEETS THE CRITERIA FOR AN ACCEPTABLE CASE NUMBER. COMPLETE SECTION B & C <b>OR</b>  <input type="checkbox"/> <b>FOSTER CHILD</b> —COMPARE THE FOSTER CHILD'S PERSONAL INCOME TO THE GUIDELINES. COMPLETE SECTION B & C <b>OR</b>  <input type="checkbox"/> <b>HOUSEHOLD INCOME</b> —COMPLETE THE INFORMATION BELOW AND COMPLETE SECTION B & C  TOTAL HOUSEHOLD SIZE: _____  TOTAL HOUSEHOLD INCOME \$ _____ / _____ <i>EXAMPLE: \$100/WEEK</i>  COMPARE TOTAL HOUSEHOLD INCOME TO CURRENT USDA INCOME ELIGIBILITY GUIDELINES. WHEN THE HOUSEHOLD INCOMES ARE LISTED FOR DIFFERENT PAY PERIODS, YOU MUST CONVERT ALL INCOME TO MONTHLY OR ANNUAL INCOME. USE THE CONVERSION LISTED ABOVE.	<b>SECTION B</b> BASED ON THE INFORMATION PROVIDED, THIS APPLICATION WILL BE: <input type="checkbox"/> APPROVED FREE <input type="checkbox"/> APPROVED TIER I <input type="checkbox"/> APPROVED REDUCED <input type="checkbox"/> APPROVED TIER II <input type="checkbox"/> PAID <input type="checkbox"/> APPROVED TIER II MIXED  <input type="checkbox"/> <b>TEMPORARY APPROVAL</b> <input type="checkbox"/> NA THIS APPLICATION REPORTED ZERO INCOME OR A TEMPORARY REDUCTION IN HOUSEHOLD INCOME. <input type="checkbox"/> APPROVED FREE <input type="checkbox"/> APPROVED REDUCED TEMPORARY APPROVAL IS GOOD FOR 45 DAYS AND EXPIRES ON _____ (DATE). RE-EVALUATE AFTER THAT DATE.  <b>SECTION C</b>  _____ SIGNATURE OF SPONSOR REPRESENTATIVE  _____ DATE OF APPROVAL  <b>THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED=</b>