



Congratulations!!

Your child is enrolled, or you may be considering enrolling your child, in a learning and development program whose level of quality exceeds Ohio's child care licensing standards.

High quality learning and development program settings are important because early experiences last a lifetime. Your child has 1,892 days from the day they are born until they enter kindergarten. What happens on this journey lays the foundation for success in school and life.

A Step Up To Quality One-Star rated program means that your child is in a program where:

- **The administrator, lead teachers and assistant teachers complete 20 hours of specialized training every two years.**
The administrator and teaching staff are committed to expanding their knowledge and skills to better support your child's development and learning.
- **Teachers are familiar with Ohio's Early Learning and Development Standards.**
Your child's program is aware that there are standards that explain child development and this information assists teachers in supporting your child's growth and learning.
- **The program focuses on building relationships with families.**
The program builds relationships with families and makes information available about community services and resources that support all family structures.
- **The program is committed to continuous improvement.**
Your child's program focuses on the continuous improvement process, and looks for ways to make their good program even better. By conducting self-assessments, the program is working to identify areas of strength and opportunities for improvement.

For more information on your program or other star rated programs visit www.odjfs.state.oh.us/cdc/query.asp

To stay current with information regarding learning and development programs in your area and statewide, visit www.earlychildhoodohio.org



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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email				
Where can you be reached while your child is in this program/home?				
Emergency Contacts: Parents <u>cannot be listed</u> 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? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> 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:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

<u>Give <i>Permission</i> to Transport</u>		<u>Do Not Give <i>Permission</i> to Transport</u>
Program or Home Name Fayette County Family YMCA - SACC	OR Do not sign both	Program or Home Name
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature _____ Date _____		Parent's Signature _____ Date _____

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>
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.

YMCA SCHOOL AGE CHILD CARE REGISTRATION APPLICATION
2018 - 2019 School Year

Child's Name _____ Age _____ Date of Birth _____

Parent's Name _____ Date of Birth _____

Address _____ City/ State _____

Zip _____

Home Phone _____ Cell Phone _____ Work _____

Email _____

Are you a current member of our YMCA? _____

If so, type of membership: Family _____ Single _____ Youth _____

Does your child have special needs? Yes _____ No _____

If yes, does your child have an IEP? *Yes _____ No _____

**Please provide the YMCA with the most current copy of your child's IEP. Please allow 72 hours to assess your child IEP before enrollment.*

Are there any custody agreements that we need to be aware of?

Yes _____ No _____

If yes, please attach a certified copy of your custody agreement.

Please name your child's legal guardian(s).

Child's first date of attendance _____

Registration to last until: (Please check one)

Continual _____ School Year Only _____ Calendar Year _____

Enrollment: Please check one

___ Full Time (Before and After School)

___ Before School Only

___ After School Only

YMCA SCHOOL AGE CHILD CARE REGISTRATION APPLICATION
2018 – 2019 School Year

School Information:

School your child attends: _____

My Child (please circle an option) will / will not need transportation for school. If so:

___ From YMCA to School – AM

___ From School to YMCA – PM

Transportation is provided to Miami Trace Middle School and Elementary, Belle Air Intermediate and Cherry Hill Primary by the bussing from the respective schools.

Transportation to and from Washington Court House Middle School will be provided by the YMCA Vans.

It is your responsibility to provide transportation information to the SACC Program (740) 335-0477 for the following reasons:

- If your child will need transported to KWOL (Sugar Creek Only)
- If someone else will be picking up your child from SACC.
- If your child was picked up from school by a parent.
- If your child will be out sick.
- If your child will be out for an extended period of time (Vacations).

Please sign here to acknowledge your understanding of the above policy.

_____ Date _____

Due to Registration Requirements and Complaisance Standards, we are required to keep a record of racial and ethnic percentages. Please check the appropriate box below:

- Caucasian
- American Indian
- African American
- Asian / Pacific Islander
- Hispanic
- Other _____

Preferred Language: _____

YMCA SCHOOL AGE CHILD CARE REGISTRATION APPLICATION
2018 – 2019 School Year

The Child Care Staff would appreciate your cooperation in filling out this form. This will help the staff get to know your child and your family. It will help us build relationships and common goals for our program.

1. List your child's favorite toys/games:
2. Does your child have any particular fears?
3. What advice can you offer our staff in working with your child?
4. Briefly describe the method(s) you utilize in disciplining.
5. How would you describe your child's behavior in school?
6. Describe your child's personality.
7. Is your child easy or hard to manage?
8. Describe your child's relationship with peers. What role does your child assume?
9. What things tend to upset your child?
10. How might your child react to a stressful situation?

YMCA SCHOOL AGE CHILD CARE REGISTRATION APPLICATION
2018 - 2019 School Year

THE FOLLOWING PEOPLE ARE AUTHORIZED TO PICK UP MY CHILD:

Child's Name _____

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Parent/Guardian Signature	_____ Date

PHOTO ID WILL BE REQUIRED FOR PICK UP OF ANY CHILD IN THE YMCA PROGRAM.

YMCA SCHOOL AGE CHILD CARE REGISTRATION APPLICATION
2018 – 2019 School Year

Parental Agreement

1. I agree to pay an enrollment fee for the 2017-2018 school year program (SACC). I understand that this fee is non-refundable. An enrollment fee of **\$50** is required before attendance can begin.
2. I understand that a three week withdrawal notice is required when withdrawing my child from the YMCA program. I understand that if I do not provide a notice I will be charged the weekly tuition.
3. I understand that my child's tuition fees are based on enrollment, not attendance, and that there is not adjustment for non-attendance. No adjustment fees is made for holidays.
4. I understand that I will be provided with two weeks "vacation" rates. I understand that I will be charged a half-price rate. I understand that once the two weeks have been used I will be charged regular rate for any additional weeks off.
5. I agree to pay the weekly rate of \$_____ for child care services.
6. I understand that a 15% discount off the regular tuition fee will be given for each additional child I may enroll at the child care center. The discount will be subtracted from the lowest regular tuition rate of any child I enroll.
7. I understand the hours the center is in operation. I understand that my child may not be dropped off and left unattended before the center opens. If my child has not been picked up or contact with child care staff has not been established, I understand that the center will contact Child Protective Services.
8. I understand that the YMCA will not assume responsibility for the children before they have arrived at the center or after they have left the center while they are on school transportation to and from school.
9. I understand that the YMCA reserves the right to make changes in its program, policies, and fees after notice has been given to parents.
10. I understand that staff are mandated reports of suspected child abuse and neglect and have the right to contact Child Protective Services as they deem necessary.
11. I agree to cooperate with the center by seeing that my child is in good state of health every day before he/she attends the center.
12. I understand that expenses obtaining any necessary medical treatment for my child are my responsibility.
13. I am aware that it is my responsibility to read and understand the information and policies in the parent handbook.
14. I understand that the YMCA is not responsible for anything that may happen as a result of false information.
15. I understand that any attempts to solve a particular problem will include an evaluation, parent conference, and many attempts to solve the problem.
16. I understand that I am bound to the terms of my child's enrollment and this contract until I have a 3-week notice of any desired changes to the director in writing.
17. I agree to cooperate with the center with any governmental laws, rules, and regulations that may affect the operation of this licensed child care center.
18. I understand that the YMCA reserves the right to terminate a child's enrollment if the administration determines that it is not in the best interest of the child or the program.
19. I understand that the Fayette County Family YMCA requests consent to release photographs, slides, moving picture, and audio/visual tapes of children enrolled in our program for the purpose of YMCA records, public relations, and/or advertising, videos, voice or text material, and either with or without my child's name or photo accompanying quotation.

Signature of Parent/Guardian

Date

Signature of Administrator

Date

YMCA SCHOOL AGE CHILD CARE REGISTRATION APPLICATION
2018 - 2019 School Year

For Office Only:

ODJFS: _____ Copay: _____

Authorization Start: _____

Authorization End: _____

Sugar Creek: _____

Wingate: _____

Full Pay: _____

Fayette County YMCA School Age

Photo Release

I, _____ give permission for my child

_____ Photo to be shared in the following ways:

(Please initial what you agree with)

_____ Photo of my child to be shared in the classroom

_____ Photo of my child to be shared in the center newsletter

_____ Photo of my child to be shared on the School Age Facebook Page (closed page, you must request to join)

_____ Photo of my child to be shared on the Fayette County YMCA website

_____ Photo of my child to be shared in the newspaper

Parent/Guardian Signature

Date

Director Signature

Date

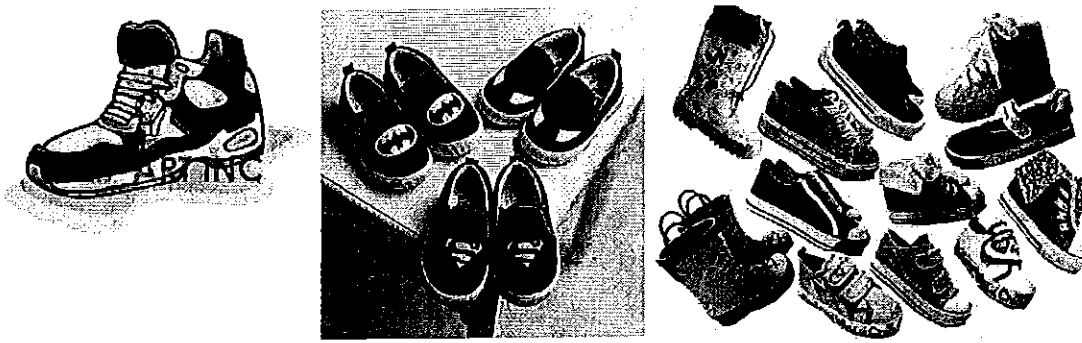
Fayette County Family YMCA

Shoe Policy Statement

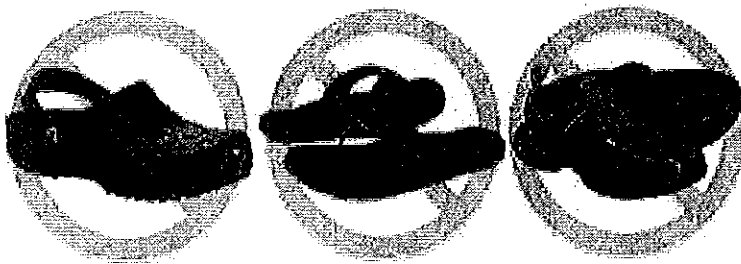
Dear Parents and Guardians,

I _____, understand that my child(ren) are required to wear closed toe shoes while attending YMCA SACC program and that I will receive a phone call to bring appropriate shoes if my child(ren) are not wearing closed toe shoes.

Approved closed-toed shoes:



Non-Approved shoes:



Parent Signature _____ Date _____

Director Signature _____ Date _____



FOR YOUTH DEVELOPMENT®
 FOR HEALTHY LIVING
 FOR SOCIAL RESPONSIBILITY

May 2, 2018

For families receiving Publicly Funded Child Care (Title 20):

Please be aware that **you are required to swipe** your child(ren) daily as this is **your** form of payment for child care. Once you swipe your child(ren), it notifies the state to keep track of your hours for the day/week in the online portal. The YMCA will receive payment from the state for the child care 3 weeks later. The administration at the YMCA checks to ensure that swipes are completed daily to ensure completion. If a parent fails to swipe, the YMCA will notify you with a back swipe slip that must be completed the day you receive it or within 5 business days. Any failure to swipe will result in the parent or guardian being financially responsible for the day(s) missed. I have provided a breakdown of cost for missed swipes below.

If you are awaiting approval from ODJFS for child care benefits the YMCA will allow your children to attend for 3 weeks. After the 3 weeks if you have not received an approval or denial you will be charged the current rates (see chart below). Once you receive approval the YMCA will reimburse you for the amount paid minus your co-pay. Also, once you receive approval you will be responsible for paying your co-pay for the weeks prior.

Lastly, the Department of Job and Family Services is updating their process of checking children in and out. They are sending all child care facilities **tablets** for parents and guardians to use to check in their children. Once we receive these tablets there will no longer be a back swipe period. You will be responsible for checking your children in and out daily and failure to check your children in/out will result in **you being financially responsible** for any missed check in/out. All payments from missed swipes will be due Friday of the current week missed. Failure to pay will result in termination of child care with the YMCA and you will be reported to ODJFS for failure to swipe. ODJFS may terminate all child care benefits until the outstanding balance is paid in full.

	Infant	Toddler	Preschool	School Age	Summer
Full Time	\$165.49	\$134.83	\$120.08	\$67.16	\$114.62
Part Time	\$103.09	\$88.91	\$66.37	\$47.15	\$67.71
Hourly	\$7.16	\$6.06	\$3.39	\$2.79	\$2.49

*If you have a co-pay, the co-pay will be deducted from the amount above to determine your balance.

By signing below you are agreeing to the above statements and understand that you will be financially responsible for any missed swipes for ODJFS.

 Parent/Guardian Signature Date

 Director Signature Date

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 more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that 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 four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

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 Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services 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 age 18 in afterschool care programs in needy areas.

Contact Information

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

Sponsoring Organization/Center	Child Nutrition Programs
YMCA Kid's World of Learning	Ohio Department of Education
100 Civic Drive	25 S. Front Street
Washington CH, OH 43160	Columbus, Ohio 43215
740-335-0477	(877) 644-6338



USDA is an equal opportunity provider and employer

USDA Nondiscrimination 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, religious creed, disability, age, political beliefs, 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.

Ohio Department of Education - Office for Child Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

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

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

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

CENTER NAME Fayette County Family YMCA

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

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

Check (✓) Days Child Normally in Care	List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule

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

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

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 (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.

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS Fiscal Year 2017 -- 2018

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 <u>Fayette County Family YMCA</u>		CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)	PART 2 - LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT LIST SWIPE CARD NUMBER. 600... numbers not valid.	
PART 1 - PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER			Check type <input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)	
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE		CASE NO.
1.			<input type="checkbox"/>	_____
2.			<input type="checkbox"/>	_____
3.			<input type="checkbox"/>	_____
4.			<input type="checkbox"/>	_____

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	<input type="checkbox"/>	\$ 200 / weekly	\$ 150 / twice month	\$ 100 / monthly	\$ _____ / _____
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Check if applicable) <input type="checkbox"/> 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).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other
Please mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> 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: 7/6/2017

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 (bi-weekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12		Application Certified/Categorized as:	
Total Household Size: _____	Total Household Income: \$ _____ Per: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household Size & Income <input type="checkbox"/> Foster Child	
		<input type="checkbox"/> REDUCED, based on Household Size & Income	
		<input type="checkbox"/> PAID, based on <input type="checkbox"/> Income Too High <input type="checkbox"/> Incomplete <input type="checkbox"/> 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 United States 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 10 or 12-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 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 either by mail at U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442, or email to program.intake@usda.gov. USDA is an equal opportunity provider.

REDUCED INCOME ELIGIBILITY GUIDELINES – 185%

Guidelines to be effective from July 1, 2017 through June 30, 2018

Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	YEAR	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	22,311	1,860	930	859	430
2	30,044	2,504	1,252	1,156	578
3	37,777	3,149	1,575	1,453	727
4	45,510	3,793	1,897	1,751	876
5	53,243	4,437	2,219	2,048	1,024
6	60,976	5,082	2,541	2,346	1,173
7	68,709	5,726	2,863	2,643	1,322
8	76,442	6,371	3,186	2,941	1,471
For each additional family member, add	7,733	645	323	298	149