Early Childhood Education Arts Academy

Christina Cultural Arts Center
705 N. Market Street Wilmington, DE 19801
Phone: (302) 652-0101 Fax: (302) 689-4719

Who We Are

The Early Childhood Education Arts Academy (ECEAA) is operated by the Christina Cultural Arts Center, Inc. funded through State and Federal sources, the Academy implements Head Start guidelines as its base requirements.

The Early Childhood Education Arts Academy embraces the philosophy that all children can learn and reach their highest potential when given the opportunity to be nurtured by involved parents, and to be taught by teachers who believe they can learn and excel. Parent engagement is key to child success. We provide systems for to participate and provide valuable input and feedback to the ECEAA community.

Our Star 5 program provides a culturally relevant, arts enriched learning experience that will prepare your child for kindergarten.

What We Do

Through the dedication of a Curriculum Coordinator, Lead Teacher and Assistant Teacher, the teaching team facilitates developmental achievement through exploration, and further educations the children through and in the Arts. Early Childhood Education Arts Specialists trained in the areas of music, movement, drama, and visual arts work with the children engaging and stimulating their natural creativeness and curiosity. The basic components of Head Start are also incorporated (i.e. health assessments/ Screenings, home visits, parent empowerment workshop, policy council, etc.) to maximize the opportunities for parent involvement.

Program Schedule

Our school year runs from September until June. The Arts day starts with breakfast at 8:30 a.m. and ends at 4:00 p.m. Extended care options are available, contact the ECEAA Director for more details.

Who is Eligible?

If you are the parent or Guardian of a child who will turn 3 ½ years old (42 months) on or before August 31, 2020 your child is eligible for the Arts Academy. **Families with special needs are encouraged to apply.**

Families meeting the attached income guidelines may be eligible for half day tuition free services. All income eligible families are prioritized according to the results of our enrollment point system. There are tuition slots available for parents who do not meet income guidelines. Our program does accept Purchase of Care.

How do I apply?

Applications for 2020 - 2021 may be picked up in the Registrar's Office on the 1st floor during normal business hours or emailed to you. Completed applications (see required documentation on application) may be submitted to the main office, faxed, or mailed. **Applications are not considered complete until all required documents are received. Once documents received acceptance in the program not obtained until parent interview complete by phone or in person.**

INFO REQUIRED FOR ENROLLMENT PROCESS

A complete application consists of the following items:

- Child's original birth certificate
- TANF verification (if applicable)
- 2 most recent pay stubs/letter from employer/agency verifying income
- Custody Consent form (if applicable)
- IEP (If applicable)
- Medical insurance card (Medicaid or other)
- Completed physical form for the current year **with lead, hemoglobin, and HCT results**
- Completed Dental Form or appointment card*
- Consent for treatment Form
- CACFP form
- Emergency Contact Sheet
- Authorization of Release Form
- Permission for Television and Video Viewing Form
- Photography Release Form
- Permission for Computer Usage Form
- Field Trip Permission Slip Form
- Permission for Program Screening Form

**Children must receive a dental screening-parents are required to complete this prior to the 1st day of school. We will accept confirmed dental appointments that are due after that date if they are scheduled within 30 days from the start date of the program*

INCOME ELIGIBILITY

The 2019 poverty guidelines are in effect as of February 1, 2019 (Federal Register vol. 84 pages 1167 – 1168).

2019 POVERTY GUIDELINES

FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

# OF PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

** For families/households with more than 8 persons, add $4,420 for each additional person.*

ONLINE SCREENING – AGES & STAGES QUESTIONNAIRE (ASQ)

Once all documents are submitted and parent interview complete, Ages and Stages Questionnaires (ASQ) need to be completed. Call the Director or Family Service Coordinator to set up an appointment.

Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. You've been invited to participate in the **Ages & Stages Questionnaires, Third Edition (ASQ-3)** and **Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE-2)** to help you keep track of your child's general growth and social emotional development. You will be asked to answer questions about things your child can and cannot do. One questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving, and personal social skills. The second and final includes questions about your child's ability to calm down, take direction and follow rules, communicate, perform daily activities (e.g., eating, sleeping), act independently, demonstrate feelings, and interact with others.

MEET & GREET EVENTS AND HOME VISITS

Children and parents in the process or accepted into the ECEAA program are invited to a meet and greet event which will take place in either June or July of 2020.

Also, families accepted into the program will be contacted by ECEAA staff to complete home visits during the month of August. Within this meeting we will gather information about your child and family and set goals.

QUESTIONS

If you have any questions, please feel free to contact the Early Childhood Education Arts Academy Director or Family Service Coordinator at (302) 652-0101.

We are also available by email:

Daphne Evans – Family Service Coordinator devans@ccacde.org
Shysheika Edwards – Center Director sedwards@ccacde.org

Our fax number is: (302) 689-4719

Early Childhood Education Arts Academy
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705 North Market Street, Wilmington, Delaware 19801
(302) 652-0101 Phone (302) 689-4719 Fax
Academic Year 2020 - 2021

Application Date: _____

Please mark all that applies: ECAP _____ POC_____ Tuition _____
☐ Income Verified ☐ Current ☐ Tuition/Non-POC

ECEAA Staff Only: Acceptance Date_____ Enrollment Date_____

Please check to reassure that all applicable documents below are included with your application:

_____Birth Certificate
_____IEP (if applicable)
_____Custody Consent Form (if applicable)
_____Proof of Income i.e. 2 pay stubs/TANF
_____ Current Medical Insurance Card
_____ Physical Form w/Lead/ Hemoglobin/HCT
_____ Dental Form or appt. card
_____ Consent to Treatment
_____ Emergency Contact Sheet
_____ Authorization to Release
_____ Television & Video Viewing
_____ Photography Release
_____ Computer Usage
_____ Field Trip Permission
_____ Program Screening form
_____ CACFP form

STUDENT INFORMATION

Date of Birth_____

Name: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Parent Email Address: _____

Has child attended child care in the last two years? _____Yes _____No
If yes please list the name(s):_____
Briefly explain your reason for transition to our program? _____
_____

PARENT INFORMATION

Primary Caretaker(s)

Date of Birth _____

Name: _____ Relationship to Child: _____
(First) (Middle) (Last)

Place of employment/name of school: _____

Work/Daytime Phone: _____ Cell Phone: _____ Evening Phone_____

Marital Status: ____Single ____ Married _____ Separated _____Divorced

Is there a secondary Caretaker (i.e. non-custodial parent, grandparent in home)? ____Yes ___No

Name: _____ Relationship to Child: _____
(First) (Middle) (Last)
Place of employment/name of school: _____

Work/Daytime Phone: _____ Cell Phone: _____ Evening Phone_____

Marital Status: ____Single ____ Married _____ Separated _____Divorced

Non-Custodial parent information: Date of Birth _____

Name: _____ E-mail: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Primary Caregiver Questions
Are you a teen parent? ❑ Yes ❑ No

Highest level of school completed:

❑ Grade 11 or less ❑ High School ❑ Associates ❑ Bachelors ❑ Masters

Work/Daytime Phone: _____ Cell Phone: _____ Evening Phone_____

How did you hear about our program?

❑ Flyer ❑ Social Media ❑ Website Search ❑ Pamphlet ❑ Referring Agency

❑ Employee: _____ ❑ Other: _____

INCOME INFORMATION

*A household consists of the child you are applying for, any adult caretakers for that child, and the siblings of that child who all reside in the same home

Total Number in Household*: _____ Income Amount: _____

Number of children in Household*: _____ Number of Adults in household*: _____

Frequency of Income: ____Weekly _____Bi-Weekly _____Monthly _____Yearly

Employed: ❑ Full-time ❑ Part-time ❑ School or Training ❑ Retired or Disabled

❑ Unemployed

Source of Income: _____ Wages _____ Social Security _____TANF

_____ Child Support _____Unemployment _____ Other (specify)

Evidence of Income _____ Payroll Stubs (2) _____ Previous year's taxes _____W-2 Forms

_____ S.S. Award Letter _____ TANF Documents _____Other (specify)

_____Foster Care Document _____Unemployment Compensation

Did you previously receive State Purchase of Care for child care expenses? ____Yes ____No

I/we certify that the above is true to the best of my /our knowledge. I understand that purposeful misrepresentation of information will result in the rejection of my application.

_____ _____

(Parent/Guardian) (Date)

_____ _____

(Parent/Guardian) (Date)

ECEAA does not discriminate based on race, color, national origin, sex, age, or handicap.
Title 16, Chapter 9, Sections 901 to 909 requires that ECEAA staff report all sexual abuse, child abuse, and/or neglect to the Division of Child Protective Services. Rev. 01/09

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN,
YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

Family Child Care
Large Family Child Care Home
Day Care Center

NAME_____

BIRTHDATE_____

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

❑ Allergies (food, medicine, bee sting etc.)	❑ Frequent Colds	❑ Fainting	❑ Physical Handicap
	❑ Hearing Difficulty	❑ Speech Difficulty	❑ Behavior Problem
❑ Constipation/Diarrhea	❑ Seizures	❑ Vision Difficulty	❑ Asthma

Other_____

Comments:_____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):

_____

_____

Parent/Guardian's Signature_____ Date_____

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin	_____ Heart	_____ Vision	_____ Ear, Nose	_____ Lungs
_____ Hearing	_____ Throat	_____ Abdomen	_____ Blood Pressure	_____ Eyes
_____ Genitalia	_____ Teeth	_____ Extremities	_____ Neck, Glands	_____ Nervous System
_____ Height	_____ Weight			

REMARKS AND RECOMMENDATIONS: _____

_____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	

Examiner's Signature_____ ❑ M.D. ❑ P.N.P. Date:_____

Printed Name:_____ Telephone:_____

DOC.NO. 37-06-10-01-01-01

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DENTAL VISIT FORM

NAME: _____ **DATE OF BIRTH:** _____

DATE OF VISIT: _____

SCHEDULED SERVICE (check all that apply):

- ❑ Oral Examination
- ❑ Cleaning
- ❑ Fluoride
- ❑ x-ray
- ❑ sealant
- ❑ filling
- ❑ extraction (temporary)
- ❑ extraction (permanent)
- ❑ root canal
- ❑ Other: _____

THIS CHILD WILL NEED MORE VISITS FOR THE FOLLOWING SERVICES (check all that apply):

- ❑ oral examination
- ❑ cleaning
- ❑ fluoride
- ❑ x-ray
- ❑ sealant
- ❑ filling
- ❑ extraction (temporary)
- ❑ extraction (permanent)
- ❑ root canal
- ❑ Other: _____

Comments:

_____

_____

_____

Examiner's Signature: _____ Date: _____
Printed Name: _____ Phone: _____
Address: _____

Consent to Treatment

I _____ am a parent/legal guardian of

_____ who is a minor child. I hereby authorize emergency medical treatment of any injury suffered by a child or any symptom that may, in the judgment of the attending medical personnel, if untreated reasonably be expected to threaten the health or life of my child. The consent provided, however, shall only be effective after reasonable attempts have been made by the attending medical personnel to obtain my consent.

Signature: _____ Relationship: _____

Witness: _____ Date: _____

Home Address: _____

Business Address: _____

Home Phone: _____ Business Phone: _____

Alternate Phone: _____ Alternate Phone: _____

Medical Insurance Information:

Name of Company: _____

Subscriber Name: _____

Policy Number: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Emergency Contact Sheet

Child Name _____

Parent/Guardian Information

Name_____ Name_____

Address _____ Address _____

_____ _____

Daytime Phone _____ Daytime Phone _____

Evening Phone _____ Evening Phone _____

Alternate Phone _____ Alternate Phone _____

Alternate Phone _____ Alternate Phone _____

If a parent/guardian cannot be contacted, please contact the following person(s) in case of emergency:

Full Name	Phone Number(s)	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child Physician: _____ Phone: _____

Child Dentist:_____Phone:_____

List any health problems or allergies: _____

_____

_____

_____

Signature: _____ Date:_____

Authorization of Release Form

Child Name _____

This form authorizes ECEAA staff to release your child for pick-up to people listed below:

Full Name	Relationship to Child
_____	_____
_____	_____
_____	_____

Picture identification is necessary for authorized people to pick up your child. This list should be updated as necessary. Please inform the Lead Teacher and/or Aftercare Teacher of any changes. If someone other than the people listed above arrives to pick up your child, ECEAA staff will not release the child into their care without first contacting you***. Please note that children will not be released to anyone who is under the influence of alcohol or drugs, or who displays inappropriate behavior, regardless to whether they are listed on this form.***

Please list phone number where you can be reached in the event of a pick-up question/concern.

_____

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Wilmington, DE 19801

Permission for Television and Video Viewing

This letter should serve as notice to the parents of the Early Childhood Education Arts Academy that the ECEAA staff must have permission to allow the children in the preschool program to view instructional/entertainment programming via television or video during the 2020-2021 program year. The television or video viewing will be limited to not more than one (1) hour per day and not more than two (2) days a week.

Please sign below indicating if you will allow/not allow your child to view programs via television or videos in their classroom.

- ❑ I give permission for my child to view videos or television in school.
- ❑ I do not give permission for my child to view video or television in school.

_____
Child's Name

_____
Parent's Name

_____
Date

Christina Cultural Arts Center
Early Childhood Education Arts Academy
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Wilmington, DE 19801

Photography Release

For valuable consideration received, I _____ grant my full and irrevocable consent to Christina Cultural Arts Center (as well as its licensees, successors, and assigns) to use, reuse, reproduce, copyright, renew copyright and license for commercial and art purposes the photographs covered by this release form.

By my signature below, I understand that such grant allows the use of these photographs in any communications or promotional medium, domestic or foreign. Further, that these photographs may be presented alone or in conjunction with photographs of other persons, objects, text or translations, and with or without my name or accompanying quotation.

Photo Subject:

Child's Name: _____

Signed: _____

Witness: _____

Date: _____

Consent by Parent or Guardian, In case of Minor

As a parent or legal guardian of person(s) named above, I consent to the terms of this release form.

Signed: _____

Witness: _____

Date: _____

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Wilmington, DE 19801

Permission for Computer Usage

This letter should serve as notice to the parents of the Early Childhood Education Arts Academy that the ECEAA staff must have permission to allow the children in the preschool program to view instructional and/or supervised age appropriate entertainment programming via computers during the 2020-2021 program year.

Please sign below indicating if you will permit/not permit your child to use programs via computers in their school.

- ❑ I give permission for my child to view and access programs on the computer in school.

- ❑ I do not give permission for my child to view and access programs on the computer in school

_____
Child's Name

_____ _____
Parent's Signature Date

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Field Trip Permission Slip

I, _____hereby give permission for _____
(parent) (child)
to attend all ECEAA sponsored field trips during the 2020– 2021 school year. I understand that public/chartered transportation will be used for trips. I agree to not hold Christina Cultural Arts Center liable for any incident that may occur.

Parent Signature: _____ Date: _____

PERMISSION FOR PROGRAM SCREENING

CHILD'S NAME _____ CENTER NAME - ECEAA

MEDICAID # _____DATE OF BIRTH_____SEX ____

The following program screenings are required or recommended by Head Start. Head Start will make arrangements for most screenings to be done. These Screenings are a part of the Head Start Program.

DENTAL SCREENING – The parent is required to escort their child to their initial screening to obtain the results to be given to Head Start. A screening shall include one or all of the following: an oral examination, cleaning, fluoride and/or x-ray. If the child qualifies, he/she will be seen at a Public Health Dental Clinic for the initial screening and follow-up treatment, at which time the FSC can transport the child to a scheduled appointment. All Dental Public Health forms need to be completed by the parent.

DEVELOPMENTAL SCREENING – An assessment of a child's abilities in the areas of speech, language, large and small motor development and cognitive skills. These results will help us assess your child's future success in school. This screening is done by the local school district personnel.

HEARING SCREENING – An audiometer, using headphones is used to test your child's hearing at different levels

HEIGHT/WEIGHT SCREENING – Measurements will be taken in October and again in March by Early Childhood Education Arts Academy personnel. These measurements will let us know how well your child is growing.

LEAD SCREENING – Has to be done by your physician.

ANEMIA SCREENING – Has to be done by your physician.

VISION SCREENING – Visual acuity and Strabismus screenings are done to screen the child's ability to see at a distance and to assess eye coordination.

ECEAA WILL NOTIFY YOU OF ANY ABNORMAL FINDING(S) and will assist you in obtaining further testing through other agencies if deemed necessary. All results will be given to you at the end of the program year on your child's health summary statement.

I have been informed about the above screenings and give permission form them to be performed on my child during the ECEAA Program Year of 2020 – 2021 from September to June. I also give permission for the results to be shared on a need to know basis between ECEAA, Public Health, WIC, private dentist or physician, appropriate local school and/or district.

_____Signature (Parent/Guardian) Date _____

_____Signature (Family Service Coordinator) Date _____

Delaware Department of Education
Child and Adult Care Food Program (CACFP)

ADULT INCOME ELIGIBILITY FORM

PART 1 *(Complete one application per household. Please use a pen, not a pencil.)*

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

List names of Enrolled Adult Participants.

Adult's First Name	MI	Adult's Last Name	Date of Birth	Ethnicity Hispanic or Latino? Yes	No	Race (check one or more) American Indian or Alaskan Native	Asian	Black Or African American	Native Hawaiian or Other Pacific Islander	White
				☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐

PART 2 - ENROLLMENT

Start Date:		Arrival Time:		AM/PM	Departure Time:		AM/PM	Shift Work:	Yes/No

Normal days of week Participant(s) is/are in care *(circle all that apply):*	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Meals eaten at Providers/Center: (*Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant*):

Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack

PART 3 – HOUSEHOLD INCOME

Do any Household Members (including you) currently receive one or more of the following assistance programs: SNAP, SSI, or Medicaid?
Check one: ☐ Yes / ☐ No

If you answered NO – Complete the Income section of Part 3.
If you answered YES – Write the name and case number for the person who receives benefits below, then go to Part 4.

NAME:_____ CASE NUMBER:_____

All Adult Household Members (including yourself)
List all Household Members not listed in Part 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is not income to report.

Names of ALL Household Members including spouse and dependent children of participant(s) (First/Last)	Earnings from Work (Before Deductions)	How Often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance/ Child Support/ Alimony	How Often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/SSI/ Retirement/ All Other Income	How Often? Weekly	Bi-Weekly	2x Month	Monthly
1	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 4 – CONTACT INFORMATION and ADULT SIGNATURE

An adult household member must **sign and date** this form before it can be approved.
"I certify (promise) that all information on this application 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 the meals may lose the meal benefits, and I may be prosecuted under applicable State and Federal laws."

Total Household Members (Children and Adults)		Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household * * * - * * - ____ ____ ____ ____	Check if No SSN ☐

Street Address (if available)	City	State	Zip	Daytime Phone and Email (optional)

Printed Name of adult completing the form	Signature of adult completing the form	Today's Date

SPONSOR USE ONLY:

Categorical Eligibility (If Yes, Check One): ☐ SNAP (Food Stamp) ☐ SSI ☐ Medicaid

DATE WITHDRAWN: _____

Total Household Income: _____ Family Size: _____ (Include all Participants)
Yearly Income Conversion: ***Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12***

ELIGIBILITY - Based on the information provided, this application will be:

☐ Approved FREE ☐ Approved REDUCED ☐ Denied – The meals will be claimed in the PAID category.

Determining Official Signature: _____ Review/Effective Date: _____

Instructions for Completing the
Child and Adult Care Food Program (CACFP)
Income Eligibility Form

Please complete the Child and Adult Care Food Program Income Eligibility Form using the instructions below. Sign the form and return it to the center/sponsor. Call the center/sponsor if you need help.

PART 1: PARTICIPANT(s) INFORMATION:

- Print the name(s) of all Participant(s) enrolled.
- RACIAL/ETHNIC IDENTITY: We are required to ask for information about the participant's race and ethnicity. This information is important, and helps us to make sure we are fully serving the community. Responding to this section is optional, and does not affect the participant's eligibility.

PART 2: ENROLLMENT

- Start date, arrival and departure times, normal days and normal meals must be completed at the time of enrollment and/or renewal.

PART 3: HOUSEHOLD INCOME

- List current SNAP, SSI, or Medicaid Case Number for the participant. DO **NOT** complete the Income section. **Go to PART 4.**

ALL Household Members (including yourself) complete this section. List all Household Members even if they do not receive income. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is not income to report.

- Write the names of everyone in your household.
- Write the amount of income received last month for each household member (the amount before taxes or before anything else is taken out), and where it came from, such as earnings, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount *last month* was more or less than usual, write that person's usual income.

Note to Center/Reviewer: If you are uncertain of how the family receives income (monthly, weekly, bi-weekly, annually) consider the income reported as the income for the month. If this is not workable, contact the family for clarification.

INCOME TO REPORT		
Earnings From Employment:	**Pensions/Retirement/Social Security:**	**Other Income:**
Wages/Salaries/Tips Strike Benefits Unemployment Compensation Worker's Compensation Net income from self-owned business or farm	Pensions, Supplemental Security Income Cash withdrawn from savings, Retirement Income Veteran's Payments Social Security Regular contributions from persons not living in the household	Disability Benefits Interest/Dividends Income from Estate/Trusts/Investments Net Royalties/Annuities Net Rental Income Any Other Income
Welfare/Child Support/Alimony:	**Military Household:**	**Foster Child's Income:**
Public Assistance Payments Welfare Payments Alimony/Child Support	All cash income, including military housing/ uniform allowances Does not include "in-kind" benefits NOT paid in cash (base housing, medical care, clothing, food, etc.)	ONLY funds from welfare agency identified by category for **personal use** of child (clothing, school fees, etc.), funds from child's family for personal use, and earnings from other sources (i.e., occasional or part-time employment) need to be included. **DO NOT** count funds from welfare agency for shelter, care, etc.

PART 4: CERTIFICATION - SIGNATURE AND SOCIAL SECURITY NUMBER: **ALL HOUSEHOLDS** COMPLETE THIS PART.

- All Income Eligibility Forms must have the signature of an adult household member.
- The adult household member who signs the form must include the **last four digits** of his/her Social Security Number **IF** the participant is eligible for "free or reduced" based on household income. Section 9 of the National School Lunch Act requires that unless the participant's SNAP (food stamp), TANF case number is provided or the participant is a foster child or homeless, you must include the last four digits of the Social Security Number of the household member signing the statement, or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last 4 digits of the Social Security Number is not mandatory, but if a Social Security Number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP or TANF office to determine current certification for receipt of SNAP or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal action. If he/she does not have a Social Security Number, check the "I do not have a Social Security Number" box.
- If listed a **SNAP, SSI,** or **Medicaid** case number, the last four digits of a Social Security Number **is not** needed.

SPONSOR USE ONLY – Eligibility Determination: **To be completed by ADULT Care Representatives ONLY.** (1) Complete total household income and size section. Compare total Income to *Household Income Eligibility Guidelines*. When household incomes are listed from different pay persons, you must convert all income to yearly income using the conversion table listed. Follow other instructions as indicated. (2) The review/effective date can be made retroactive back to the first day of participation in the CACFP as long as it occurs in the same month this form is received.

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, i.e., Food Stamp), Temporary Assistance for Needy Families (TANF) Program 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.*