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 parents 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 educates 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, 2023 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. **Children must be potty trained.**

How do I apply?

Applications for 2023 – 2024 school year may be picked up in the Registrar's Office on the 1st floor during normal business hours or emailed to you. Completed applications (see below for required documentation) may be submitted to the main office, faxed, emailed, or mailed.

Applications are not considered complete until all required documents are received along with the initial interview by phone. Once documents are received along with initial interview ***- if a slot is available*** - families are notified and receive conditional acceptance in the program. Parents/guardians then have a week to schedule an **in-person meet & greet interview**. During this interview the Family Service Coordinator will review the **Family Partnership Agreement** and parents will fill out the **Ages & Stages Questionnaire**. In late August/September the teachers will set up Home Visits with families. Within this meeting teachers will gather information about your child and family and set educational goals with you.

A larger orientation meeting for new families will be held late August for all families.

INFO REQUIRED FOR ENROLLMENT PROCESS

A complete application consists of the following items:

- Child's original birth certificate
- SNAP Acceptance/Verification form (if applicable)
- 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**
- Allergy plan (if applicable)
- 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
- Ages & Stages Questionnaire (completed online)

Meetings needed in process

- initial phone interview
- meet & greet with Family Service Coordinator
- home visit with teacher
- orientation meeting

**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

2020 FEDERAL POVERTY GUIDELINES (FPG)
ANNUAL & MONTHLY INCOME LEVELS
FROM 100% to 250%

FAMILY	FPG (100%)		125% of FPG		150% of FPG		175% of FPG		185% of FPG		200% of FPG		235% of FPG		250% of FPG	
SIZE	YEAR	MONTH	YEAR	MONTH	YEAR	MONTH	YEAR	MONTH	YEAR	MONTH	YEAR	MONTH	YEAR	MONTH	YEAR	MONTH
1	$12,760	$1,063	$15,950	$1,329	$19,140	$1,595	$22,330	$1,861	$23,606	$1,967	$25,520	$2,127	$29,986	$2,499	$31,900	$2,658
2	$17,240	$1,437	$21,550	$1,796	$25,860	$2,155	$30,170	$2,514	$31,894	$2,658	$34,480	$2,873	$40,514	$3,376	$43,100	$3,592
3	$21,720	$1,810	$27,150	$2,263	$32,580	$2,715	$38,010	$3,168	$40,182	$3,349	$43,440	$3,620	$51,042	$4,254	$54,300	$4,525
4	$26,200	$2,183	$32,750	$2,729	$39,300	$3,275	$45,850	$3,821	$48,470	$4,039	$52,400	$4,367	$61,570	$5,131	$65,500	$5,458
5	$30,680	$2,557	$38,350	$3,196	$46,020	$3,835	$53,690	$4,474	$56,758	$4,730	$61,360	$5,113	$72,098	$6,008	$76,700	$6,392
6	$35,160	$2,930	$43,950	$3,663	$52,740	$4,395	$61,530	$5,128	$65,046	$5,421	$70,320	$5,860	$82,626	$6,886	$87,900	$7,325
7	$39,640	$3,303	$49,550	$4,129	$59,460	$4,955	$69,370	$5,781	$73,334	$6,111	$79,280	$6,607	$93,154	$7,763	$99,100	$8,258
8	$44,120	$3,677	$55,150	$4,596	$66,180	$5,515	$77,210	$6,434	$81,622	$6,802	$88,240	$7,353	$103,682	$8,640	$110,300	$9,192
*	$4,480	$373	$5,600	$467	$6,720	$560	$7,840	$653	$8,288	$691	$8,960	$747	$10,528	$877	$11,200	$933

*For family units over 8, add the amount shown for each additional member.

Online Screening – Ages & Stages Questionnaire (ASQ)

Once all documents are submitted parents can complete, Ages and Stages Questionnaires (ASQ). If not completed by the meet and greet meeting with Family Service Coordinator, it will be completed then.

Because your child's first 5 years of life are so important, we want to provide the best start for your child. Please complete the **Ages & Stages Questionnaires, Third Edition (ASQ-3)** and **Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE-2)** to give us feedback on your child's general growth and social emotional development. The forms ask questions focusing on skills your child can and cannot do. The ASQ 3 questionnaire includes topics which cover your child's communication, gross motor, fine motor, problem solving, and personal social skills. The second questionnaire (ASQ:SE-2) has parents answer 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. ***Indicate they will be attending – Early Childhood Education Arts Academy.***

https://www.christinak12.org/domain/319

Results from the ASQ will not factor in acceptance to the program. **After acceptance notice, enrollment is contingent upon parent completion of the questionnaire.**

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 – Education Director sedwards@ccacde.org

Our fax number is: (302) 689-4719

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705 North Market Street, Wilmington, Delaware 19801
(302) 652-0101 Phone (302) 689-4719 Fax
Academic Year 2023 - 2024

Application Date: ___________

Please mark all that applies: ECAP ______ POC______ Tuition _______SNAP _______
☐ 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
_____ SNAP Acceptance/Verification
_____ Completed ASQ for child (see page 3 of instructions for link)
_____ 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)

Revised 2023

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

<u>Non-Custodial parent information:</u> Date of Birth ____________

Name: ____ E-mail: ____________________
(First) (Middle) (Last)

Address: ____

City: _________________________ State: __________ Zip: ____________________

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

______ SNAP Document

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 EDUCATION
OFFICE OF CHILD CARE LICENSING (OCCL)

NAME____________________

Family Child Care Home
Large Family Child Care Home
Day Care Center
Youth Camp

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:____________________________

Revised 2023

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DENTAL VISIT FORM

NAME: ____ **DATE OF BIRTH:** _______________

DATE OF VISIT: _______________________

SCHEDULED SERVICE (check all that apply):

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

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

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

Comments:
____
____
____

Examiner's Signature: ________________________________ Date: ___________________
Printed Name: _______________________________________ Phone: __________________
Address: ____

Revised 2023

Medical and Religious/Cultural Food Restrictions –
Children & Adults

Participant Name: ____
Participant Date of Birth: _________________ Participant Age: _________________

Emergency Contact Information:
Name: ________________________________Relation to Participant: ____________
Home: __________________ Work: ________________ Cell: ___________________

Please list the foods that the participant may not have, list suggested substitutions, and describe the allergic reaction (if applicable).

1. **Food Allergy(ies)** ❑ Yes ❑ No

❑ wheat ❑ peanuts ❑ tree nuts ❑ milk ❑ fish ❑ eggs ❑ shellfish ❑ soy

____other (please specify) ____
Please list recommended substitutions for foods listed above:
____
____
Must this food(s) be avoided in all forms and/or in even small amounts? ___________
Please describe the participant's typical allergic reaction:
____
____

2. Dietary Restrictions
(including those for medical, religious, cultural or other reasons) ❑ Yes ❑ No
If yes, what is the nature of the restriction? ❑ Medical ❑ Religious/Cultural
If yes, please list the restricted foods: _______________________________________
Please list substitutions for foods listed above: ________________________________
____
Must this food be avoided in all forms and/or in even small amounts? ____________

Medical Professional Name (please print): ___________________________________

Medical Professional Signature: _______________________________ Date: ______

Parent/Guardian Signature (childcare only): _____________________ Date: ______

Notice of Child Allergy or Health Issues

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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Release of Information for Funding

Dear Parent,

As part of participation in our programs, we collect information about all of our participants, so we know who we are working with and can share that information (grouped together) with organizations that provide funding for the programs. Because some of the funding for this program comes from the State of Delaware as part of the Healthy Women, Healthy Babies Initiative, we will be sharing grouped information with the State.

The data are confidential. When information is shared, it will be in the following ways:

1. Data will be grouped together and put into summary reports to the Delaware Division of Public Health so they can understand what is working and helping people be healthier
2. Individual data may be shared with the Division of Public Health but only **without identifiers**. That means your name, your address, your birth date and other information that could identify you will not be released to anyone outside of the staff and evaluation team.

Your participation is voluntary, and you do not have to participate. If you decide you do not want your information shared, nothing will change in terms of your ability to access services and participate in programs with us. If you have any questions this, you may reach out to Daphne Evans, Family Service Coordinator at devans@ccacde.org or Shysheika Edwards, Education Director, sedwards@ccacde.org.

❑ I agree that ECEAA can release information.

_______________________________________ ________________________

(Parent/Guardian) (Date)

Christina Cultural Arts Center
Early Childhood Education Arts Academy
705 N. Market Street
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: ____

Christina Cultural Arts Center
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705 N. Market Street
Wilmington, DE 19801

Field Trip Permission Slip

I, ____________________________hereby give permission for ____________________________
(parent) (child)
to attend all ECEAA sponsored field trips during the 2023– 2024 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 2023 – 2024 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)

CHILD 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." Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Read How to Apply for Free and Reduced Price School Meals for more information.

Child's First Name	MI	Child'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	Foster Child	Homeless, Migrant; Runaway
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐

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 participate in one or more of the following assistance programs: SNAP or TANF?
Check one: ☐ Yes / ☐ No

If you answered NO – Complete Part 3. **If you answered YES** – Write a case number below, then go to Part 4
Case Number: (Write only one case number in this space)

A. Child Income
Sometimes children in the household earn income. Please include the TOTAL income earned by all Child Household Members listed in PART 1 here.

Child Income	How Often? Weekly	Bi-Weekly	2x Month	Monthly
$	☐	☐	☐	☐

B. 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.

Name of Adult Household Members (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 this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose 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) Household
☐ TANF Household ☐ Head-Start ☐ ECAP ☐ Foster Child(ren) ☐ Homeless/Migrant/Runaway Participant(s)

DATE WITHDRAWN: ________________

Total Family 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)

Revised 2023

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 your current SNAP Case Number or TANF Identification Number for the participant. DO **NOT** complete Part 3A OR 3B. **Go to PART 4.**

PART 3A:

ONLY HOUSEHOLDS ENROLLING A FOSTER CHILD, or if children in the household earn income: COMPLETE THIS SECTION. Refer to specific instructions indicated. All foster children indicated in PART 1 should be included.

PART 3B:

ALL Adult 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.
- An adult household member reporting total household income must sign the form and include the **last four digits** of his/her Social Security Number in **PART 4.**

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 you listed a **SNAP** or **TANF** case number or the participant is a **Head Start, ECAP**, **Foster** or **Homeless** child, the last four digits of a Social Security Number **is not** needed.

SPONSOR USE ONLY – Eligibility Determination: **To be completed by Child 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.

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 submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other 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 or other FDPIR identifier for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

USDA Nondiscrimination Statement (October 14, 2015)

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

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

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

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

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

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

This institution is an equal opportunity provider.

Child's Name ____________________________

PARENTS RIGHT TO KNOW AND PERMISSIONS PARENTS RIGHT TO KNOW NOTICE

Per the Delaware code, you are entitled to inspect the active record and complaint files of any licensed child care facility. To review a record contact: the administrative specialist, Office of Child Care Licensing, 3411 Silverside Road, The Concord | Hagley Building, Wilmington, Delaware 19810, phone (302) 892-5800. You may also view substantiated complaints and compliance review histories for the past five years by visiting the Office of Child Care Licensing's child care search at https://education.delaware.gov/families/occl/child_care_search/. I acknowledge I received this notice as part of the application packet.

________________________________ ________________

Parent/Guardian Signature **Date**

PARENT PERMISSION FOR SCREEN TIME USAGE

Children over the age of two may have an educational video, movie, or game incorporated into their curriculum. These may be viewed on a television, computer, tablet, or gaming device. These will be age-appropriate and limited to one hour per day unless a special occasion or activity occurs. Children will be closely supervised while using the internet. I hereby authorize my child to have screen time activities.

________________________________ ________________

Parent/Guardian Signature **Date**

PARENT PERMISSION TO SLEEP ON A MAT

Children between the ages of 12 and 18 months will be transitioned from sleeping in a crib to a cot, mat, or bed when they are able to walk. I hereby authorize my child to sleep on a cot, mat, or bed.

________________________________ ________________

Parent/Guardian Signature

CHILD INFORMATION CARD
State of Delaware
Department of Education

Child's Information			
Child's name:	Date of birth:	Date of enrollment:	Date of discharge:
Child's address:		Hours and days child is scheduled to attend:	
Parent/Guardian Information (1) Emergency Contact/Authorized to Pick-up Child		**Parent/Guardian Information (2)** Emergency Contact/Authorized to Pick-up Child	
Name:		Name:	
Address, if different from child's:		Address, if different from child's:	
Home phone:	Cell phone:	Home phone:	Cell phone:
Work phone:	Hours of employment:	Work phone:	Hours of employment:
Employer name and address:		Employer name and address:	

Additional Emergency Contacts and People Authorized to Pick-up Child		
Name:	Address:	Phone:
Name:	Address:	Phone:
Name:	Address:	Phone:

☐ **Emergency Medical Care**

I, ______________________________, the parent (or legal guardian) of ______________________________, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

☐ **Transportation**

I, ______________________________, the parent (or legal guardian) of ________________________________, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute.

______________________________ ______________________________
Signature of parent/guardian Date

Medical Information	
Name of child's physician:	Office phone:
Special medical information, medications, allergies, diet:	Health insurance identification information:

The above information is necessary for your child's protection and this facility is required to have it. Keep this information current.

Created by the DE Office of Child Care Licensing. Revised July 2015. Facility must retain this information for 3 months after child is removed from care.