2013-2014 Contract

School Kids In Peterborough

14 Vine Street • Peterborough NH 03458 • 603 924-7050 Phone/Fax

_____New Contract _____Contract Change _____Contract Cancellation

Registration Fee___$25(Child) _____$35(Family*____

(_____) Cash (_____) Check#_____

Parent(s) Name:_____

Address:_____

Town/State/Zip:_____

Telephone:_____

E-mail:_____

☐ I would prefer electronic billing at the email above ☐ I prefer paper bill picked up at SKIP

I hereby contract with SKIP Inc. to provide childcare for the listed children on a weekly basis, for the balance of the ConVal School Year.

Child's Name:_____Age:___Grade___Teacher_____Start Date:_____

Date of birth:_____

minimum 2 days/ week or will be billed at drop-in (emergency) rate.

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Mornings						
PM till 6PM						

Weekly 'Total $_____

Child's Name:_____Age:___Grade:___Teacher:_____Start Date:_____

Date of birth:_____

minimum 2 days/ week or will be billed at drop-in (emergency) rate.

	Monday	Tuesday	Wednesday	Thursday	Friday	Cost
Mornings						
PM till 6PM						

Weekly Total $_____

By signing this form I claim financial responsibility to pay the weekly total per child on a monthly basis according to the terms on the reverse side of this contract and to abide by the financial policies. Parents are responsible for payment on occasions when SKIP is closed due to inclement weather or school holidays. This does not include February and April breaks which are contracted separately. SKIP will be closed the week between Christmas and New Years at no cost to parents. Payment due 1st of month. Late fee ($10.00) applies after 5th of month,& notification of non returnapplies if payment not received by 10th of month.

Signature_____ **Signature**_____

Thank you for taking the time to read our registration materials. By signing this form, you acknowledge that you have read our materials and understand when SKIP will be open and closed, and that you understand our special contract day policy, behavior policy, financial policy, rates, and snow day policy. Of course, we are happy to answer any new questions that may arise at any time! Thank you for sharing your child with us!

I,_____ have read and understand all registration materials.

_____ _____

(signature) (date)

7.

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

School Kids In Peterborough 4702

NAME OF CHILD CARE PROGRAM **LICENSE NUMBER**

TO THE PARENT OR GUARDIAN: This form must be completed for each of your children who will be enrolled in the program, and must be updated whenever information changes. You must also either complete a new form annually, or update this form annually by following the instructions at the bottom of the reverse side of this form.

DATE OF CHILD'S ENROLLMENT _____

Child's name:	Date of birth:
Address:	Phone number:

IDENTIFYING INFORMATION OF PARENT/S OR GUARDIAN/S LEGALLY RESPONSIBLE FOR CHILD:

Name:	Name:
Address:	Address
Home phone number:	Home phone number:
Indicate where parent/guardian above can be reached while child is in care. Include name, address and phone number of business if applicable. Include any special instructions, e.g. pager, cell phone, etc.	
Business Name:	Business Name:
Address:	Address
Phone number: Hours:	Phone number: Hours:
Special Instructions for reaching parent/guardian:	

EMERGENCY CONTACT PERSON: You (parent/guardian) are required to list at least 1 person with whom you would feel comfortable leaving your child, and who could assume responsibility for your child if you could not be reached immediately in an emergency, or if for some reason you could not pick up your child and were unable to communicate with the program. Examples: if your child were sick and you were not accessible, or if you experienced sudden illness between work and picking up your child.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

NON-EMERGENCY ALTERNATE PICK-UP PERSON/S: I,_____

(Parent/Guardian Signature) Date Signed

authorize the following individual(s) to pick up my child from the program on a non-emergency basis.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

8.

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

NON-EMERGENCY ALTERNATE PICK-UP PERSON/S Continued

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

NOTE TO PARENT/S or GUARDIAN/S: The licensing authority for this program is the Bureau of Licensing and Certification, Child Care Licensing Unit. Child care programs are required to post a copy of the statement of findings and corrective action plan for the most recent visit in a location which is accessible to parents, and must maintain copies of the statement of findings and corrective action plan for the preceding visit and make them available for parents to review upon request. Statements of findings and corrective action plans are also available on-line at http://childcaresearch.dhhs.nh.gov or by calling the unit at 1-800-852- 3345, extension 9025 or 603-271-9025.

During licensing, monitoring, and complaint investigation visits to licensed programs the department shall speak with children regarding the care they receive at the program, if in the judgment of the licensing coordinator the children's response would be valuable in determining compliance with licensing rules. Licensing staff are experienced in working with children and trained to interview in a manner that is respectful and non-leading. However, if you do not want your child interviewed, or if you wish to be informed prior to your child being interviewed you must give the family child care provider, center director, site director or designee, and update annually, a signed dated statement indicating your preference.

For more information about Child Care Licensing please visit our website at:
http://www.dhhs.state.nh.us/oos/cclu/index.htm

MEDICAL INFORMATION

Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:
Child's Usual Physician: Phone number:
Physician's Address:

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of _____ to provide simple first aid treatment to my child, _____ when necessary. In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

Parent/Guardian Signature **Date**

ANNUAL UPDATE:

PARENT/GUARDIAN MUST REVIEW THIS INFORMATION **ANNUALLY**, MAKE NECESSARY CHANGES & INITIAL & DATE BELOW TO VERIFY THAT THE INFORMATION IS CURRENT.

Parent/Guardian Initials:	Date:	Parent/Guardian Initials:	Date:
Parent/Guardian Initials:	Date:	Parent/Guardian Initials:	Date:

Child's Name_____

Operations / Serious injuries:

Chronic or recurring illness:

Dietary restrictions:

Learning Difficulties (have an aide during school?)

Physical, Social, Emotional, or Sensory needs:

Activity limitations or special conditions to be watched:

Allergies to food, drugs, insect stings, plant/pollen, animal or other:

I hereby give permission for Conval staff and SKIP staff to share their knowledge and information about my child.

Parent
Signature:_____ date:_____

Child's Name_____

Any information that you can share with us to make your child more *comfortable at SKIP is greatly appreciated and valued. We wish to make* every child's stay at SKIP as positive an experience as possible.

What three things does your child want us to know about him/her?

What three things do you, the parent, want us to know about your child?

What things does you child not like?

Things I expect from SKIP:

Please list any concerns you may have:

Doctor's Universal Health form is also acceptable.

11.

CHILD HEALTH FORM

TO BE COMPLETED BY PARENT OR GUARDIAN:

CHILD'S LAST NAME _____ FIRST NAME _____ M.I _____ DOB: MO ____ / DAY ____ / YEAR ____

CHILD'S ADDRESS _____

WE/I _____ GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL INFORMATION ON THE ABOVE CHILD.

SIGNATURE OF PARENT/GUARDIAN

PLEASE RETURN TO: _____ NAME OF CHILD CARE PROGRAM

SCHOOL KIDS IN
PETERBOROUGH, INC.
14 VINE STREET
PETERBOROUGH, NH 03458

HISTORY: TO BE COMPLETED BY PHYSICIAN
(THIS INFORMATION WILL BE HELD CONFIDENTIAL AND WILL BE USED ONLY FOR THE BENEFIT OF THIS CHILD).

A PRENATAL, PERINATAL AND POSTNATAL DEVELOPMENT: ANY SIGNIFICANT FINDINGS THAT COULD INFLUENCE THIS CHILD'S ADAPTATIONS TO A CHILD CARE SETTING (I.E., PHYSICAL HANDICAP, SENSORY LOSS, DEVELOPMENTAL IRREGULARITIES)?

B. ANY CHRONIC ILLNESS THAT MAY REQUIRE MEDICATION, PARTICULARLY OBSERVATIONS OR PRECAUTIONS IN A CHILD CARE SETTING (E.G., RECURRENT EAR INFECTIONS, SEIZURE DISORDER, ALLERGIES)?

C. ANY HOSPITALIZATIONS, OPERATIONS, OR SPECIAL TESTS OF WHICH A CHILD CARE PROVIDER SHOULD BE AWARE

D PERTINENT FAMILY, SOCIAL OR HEALTH CHARACTERISTICS?

IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE
YOU MY SUBSTITUTE A COPY OF YOUR OWN IMMUNIZATION RECORD

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

COMMUNICABLE DISEASE HISTORY

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN
CHICKENPOX		NOT APPLICABLE	
OTHER:			

RECOMMENDED SCREENING & TESTING OF ATTENDEES

	DATE	METHOD	RESULT:
TB (FOR HIGH RISK CHILDREN ONLY)			
VISION			
HEARING			
SPEECH			
HIB/HCT		NOT APPLICABLE	
URINE		NOT APPLICABLE	
LEAD		NOT APPLICABLE	

← Physician portion

12. HEALTH ASSESSMENT: (TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER

PHYSICAL EXAM:

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
____IN/CM %ILE____	____LB/KG %ILE____	____IN/CM %ILE____	____/____

CHECK (✓) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK (✓) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED
SKIN/SCALP					NOSE, THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

TEMPERAMENT: ___ EASY-GOING ___ AVERAGE ___ DIFFICULT

COMMENTS:

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

ASSESSMENT OF PHYSICAL DEVELOPMENT:

A. ESTIMATE OF LEVEL OF MATURATION:

A. INFANCY (0-2 YEARS)	EARLY: ___	MID: ___	LATE: ___
B. MID-PRESCHOOL (2-4 YEARS)	EARLY: ___	MID: ___	LATE: ___
C. PRESCHOOL (4 YEARS)	EARLY: ___	MID: ___	LATE: ___
D. SCHOOL-AGE (6-10 YEARS)	EARLY: ___	MID: ___	LATE: ___
E. ADOLESCENT (11-18 YEARS)	EARLY: ___	MID: ___	LATE: ___

COMMENTS

B. ESTIMATE OF FUNCTIONAL CAPACITY:

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS:
GROSS MOTOR:				
FINE MOTOR:				
LANGUAGE SKILLS:				
SOCIAL SKILLS:				
EMOTIONAL:				

PHYSICIAN'S SIGNATURE: _____ DATE OF EXAM: _____

PHYSICIAN'S NAME - TYPED OR PRINTED _____ TELEPHONE NUMBER _____

DATE OF NEXT SCHEDULED EXAM: _____

13. **You must fill out this form, even if you do not wish any medication to be given to your child. Read below.**

Use this form to allow us to administer prescription or non-prescription medication to your child. **We must have this to dispense any medication,** even prescription medication with a doctor's note. If you **do not** want any medication given to your child while at SKIP, check that box. If you do allow us to give Tylenol, or Advil (Ibuprofen), or Benedryl to your child you may indicate that, and indicate the conditions you are comfortable with. You may say, "call first", or administer per dosage without calling first", etc.

AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

IN ACCORDANCE WITH HE C 4002.20, THIS FORM MUST BE COMPLETED PRIOR TO THE ADMINISTRATION OF ANY PRESCRIPTION OR NON PRESCRIPTION MEDICATION
PRESCRIPTION MEDICATION WILL BE ADMINISTERED IN ACCORDANCE WITH THE PRINTED PRESCRIPTION LABEL, WHICH MUST ATTACHED TO THE ORIGINAL PRESCRIPTION CONTAINER.
NON PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER, AND WILL BE ADMINISTERED IN ACCORDANCE WITH T MANUFACTURER'S PRINTED INSTRUCTIONS. IF THERE ARE NO MANUFACTURER'S PRINTED INSTRUCTIONS FOR THE AGE OF THE CHILD, T PROGRAM MAY ADMINISTER THE NON-PRESCRIPTION MEDICATION IN ACCORDANCE WITH THE WRITTEN, DATED AND SIGNED INSTRUCTIO FROM THE CHILD'S PARENT, INCLUDING A STATEMENT THAT THE INSTRUCTIONS HAVE BEEN REVIEWED/APPROVED BY THE CHILI LICENSED HEALTH PRACTITIONER, OR WITH SIGNED, DATED WRITTEN INSTRUCTIONS FROM CHILD'S LICENSED HEALTH PRACTITIONER.

PARENT'S AUTHORIZATION
I AUTHORIZE CHILD CARE PERSONNEL AT School Kids in Peterborough TO ADMINISTER TH
NAME OF CHILD CARE PROGRAM
FOLLOWING MEDICATION TO MY CHILD: ______________________ ______________
CHILD'S NAME DATE OF BIRTH

☐ I do not authorize any administration of medication to my child while at SKIP.

NAME OF MEDICATION	DOSAGE / Weight of Child.	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE

PRINTED NAME AND PHONE NUMBER OF CHILD'S LICENSED HEALTH PRACTITIONER

PARENT/GUARDIAN'S SIGNATURE DATE SIGNED

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

THE ABOVE SPECIAL INSTRUCTIONS WERE:
☐ REVIEWED AND APPROVED BY THE ABOVE NAMED LICENSED HEALTH PRACTITIONER
☐ COMPLETED BY THE LICENSED HEALTH PRACTITIONER WHO'S SIGNATURE IS BELOW

LICENSED HEALTH PRACTITIONER'S SIGNATURE DATE SIGNED

CHILD CARE PROGRAM RECORD OF MEDICATION ADMINISTRATION

(TO BE COMPLETED BY CHILD CARE PERSONNEL FOR ALL MEDICATION ADMINISTERED)

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

Maria Samaras - Director 7/15/13

Physician must fill out this form for SKIP to administer any prescription.
Parent MUST fill out form for authorization or non-authorization of over the counter meds.

Child's Name_____

Operations / Serious injuries:

Chronic or recurring illness:

Dietary restrictions:

Learning Difficulties (have an aide during school?)

Physical, Social, Emotional, or Sensory needs:

Activity limitations or special conditions to be watched:

Allergies to food, drugs, insect stings, plant/pollen, animal or other:

I hereby give permission for Conval staff and SKIP staff to share their knowledge and information about my child.

Parent
Signature:_____date:_____

Child's Name_____

Any information that you can share with us to make your child more *comfortable at SKIP is greatly appreciated and valued. We wish to make* every child's stay at SKIP as positive an experience as possible.

What three things does your child want us to know about him/her?

What three things do you, the parent, want us to know about your child?

What things does you child not like?

Things I expect from SKIP:

Please list any concerns you may have:

Helping People. Changing Lives.
SNHS
The Community Action Program for Hillsborough and Rockingham Counties

SOUTHERN NEW HAMPSHIRE SERVICES

The Community Action Program for Hillsborough and Rockingham Counties

Mailing Address: PO Box 5040, Manchester, NH 03108
40 Pine Street, Manchester, NH 03103
Telephone: (603) 668-8010 *Fax:* (603) 645-6734
www.SNHS.org

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center that offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information.

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) or Temporary Assistance for Needy Families (TANF), can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP or TANF case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact Amy Allen, 55 Prescott Road, Raymond, NH 03077, 603-895-2303 x19.

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. ***(Pricing program only)*** **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your sponsoring organization

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call 603-895-2303 x19

Sincerely,

Amy Allen
CACFP Program Specialist
55 Prescott Rd.
Raymond, NH 03077
(603) 895-2303 ext. 19
fax # (603) 895-2330
aallen@rcaction.org

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Follow these instructions, if your household gets SNAP or TANF

Part 1: List all enrolled children AND household members.
Part 2: List the case number for any household member (including adults) receiving SNAP or TANF benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are not necessary.
Part 6: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions

If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is not necessary.
Part 6: Answer this question if you choose to.

If some of the children in the household are foster children.

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [your school, homeless liaison, migrant coordinator]. If not, skip this part.
Part 4: Follow these instructions to report total household income form this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.

- **Box 1** - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
- **Box 2** - list the amount each person got from the month from welfare, child support, alimony.
- **Box 3** - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
- **Box 4** - list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.
Part 6: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box."
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A–Name: List only the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.

Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
Box 2 - list the amount each person got from the month from welfare, child support, alimony.
Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
Box 4 - list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: An adult household member must sign the form and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 6: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Names of all Enrolled Children ***AND*** household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * *IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.*	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits

If any member of your household received SNAP or TANF cash assistance, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. Categorical Benefits

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your school, homeless liaison or migrant coordinator. Homeless ☐ Migrant ☐ Runaway☐

If no category is checked, skip to part 4.

Part 4. Total Household Gross Income —You must tell us how much and how often

A. Name	B. Gross income and how often it was received			
List **only** household members with income	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	(Example) $200/weekly	(Example) $150/twice a month	(Example) $100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ I do not have a Social Security Number

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

FOR OFFICIAL USE ONLY
Don't fill out this part.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: $_____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ❑ Homeless ❑ Migrant ❑ Runaway

Income Eligibility: ❑ Free ❑ Reduced ❑ Denied ❑ Tier I ❑ Tier II

Reason for Denial: _____

Temporary Approval: ❑ Free ❑ Reduced Time Period: _____ (expires after _____ days)

Date Withdrawn form Program: ____/____/____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	$ 20,665
2	$ 27,991
3	$ 35,317
4	$ 42,643
5	$ 49,969
6	$ 57,295
7	$ 64,621
8	$ 71,947
Each additional person:	$ 7,326

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

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Please only fill out where there is an astersk.

Child and Adult Care Food Program
CHILD AND/OR ADULT ENROLLMENT FORM

Dear Parent/Guardian:

Your child / adult's day care has been approved for participation in the USDA's Child and Adult Care Food Program, which partially reimburses Child Care Providers/Centers for nutritious meals served to children/adults in attendance. This program reimbursement supports the quality of the meal program and is beneficial to you and your child / adult *because it provides nutritious meals and snacks.*

Sponsoring Organization Name Southern NH Services, Inc.

Sponsoring Organization Phone # 603-668-8010 x 6048

Child Care Provider/Business Name School Kids in Peterborough

Sponsoring Organization CACFP Representative Name Patty Carignan, CACFP Coordinator

Annual Renewals:

Check One:

_____ I certify that the changes noted, initialed and dated below are true and accurate.

_____ I certify that the information recorded below remains true and accurate.

Parent/Guardian Signature:_____ Date:_____

***Directions:* Form must be completed by parent/guardian so that the actual time of enrollment reflects the accurate arrival and departure times each day of the child(ren) in attendance. Please ensure that this document represents the most current profile of your child(ren)'s enrollment status. Update and certify this document annually.**

Full Name of Child / Adult in Family Enrolled in CACFP	Date of Birth	Age	Time Child/ Adult Arrives at Day Care	Time Child Goes to School	Time Child Returns from School	Time Child/ Adult Leaves for Home	Days in Care							Attendance during Vacation/ No-School Days (*Circle One*)	Meals Eaten at Child Care					
							M	T	W	Th	F	Sa	Su		Bk	AM Sn	L	PM Sn	Su	BT Sn
*	* / /	*												Y N						
*	* / /	*												Y N						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						
	/ /													Y N						

Please Print

*Parent/Guardian Names _____

Mailing Address

*_____

*Home Phone #_____

Parent/Guardian Workplaces:

*Mother Phone #_____ Father Phone #_____

*_____ ***To the best of my knowledge all of the above information is correct.***

Parent/Guardian Signature

*_____

*Date _____

For CACFP Representative Use Only

Sponsor Signature

_____

Effective Date of Form: _____

Check One

( ) *New enrollment* ( ) *Annual Renewal*

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