SKIP

SUMMER 2023 CONTRACT

14 VINE STREET, PETERBOROUGH NH 03458
☎ 603-924-7050 1-508 461-2090 WWW.KIDSATSKIP.ORG
DIRECTOR@KIDSATSKIP.ORG

I WOULD LIKE MY BILL EMAILED TO THE ADDRESS BELOW. ☐
I WOULD LIKE A PAPER BILL TO BE PICKED UP AT THE BUILDING. ☐
CHILD'S TEE SHIRT SIZE: _____ (OPT) SIZE OF EXTRA TEE ($10 EA)_____
APPLIED FOR REKINDLING CURIOSITY GRANT____ APPROVED: YES NOT YET

CHILD'S NAME_____
CHILD'S DOB_____ENTERING GRADE_____
MY CHILD HAS AN IEP ☐
MY CHILD HAS AS AIDE ☐

STAFF USE: REG FEE RECEIVED DATE:_____ AMOUNT RECEIVED:_____
CASH/MONEY ORDER: ☐ CHECK: ☐ RCPT/CHECK#:_____

DATE ENROLLED (STAFF USE)_____

REGISTRATION IS NOW BEING ACCEPTED FOR THE SUMMER 2023 PROGRAM. SPACE IS LIMITED. REGISTRATIONS WILL BE PROCESSED IN THE ORDER RECEIVED. HOURS OF OPERATION THROUGH THE SUMMER ARE 6:30 AM TO 5:30 PM MONDAY - FRIDAY. PROGRAMMING WILL BE PROVIDED AT THE SKIP BUILDING, ALONG WITH WALKING AND DRIVING FIELD TRIPS. THE FEE INCLUDES BREAKFAST BEFORE 8:30 A.M., AS WELL AS TWO SNACKS AND LUNCH. IF YOU PROVIDE LUNCH NO CANDY OR SODA PLEASE. WE CANNOT REFRIGERATE LUNCHBOXES. PLEASE PACK ACCORDINGLY. THE REGISTRATION FEE INCLUDES 1 TEE SHIRT TO BE WORN ON FIELD TRIPS. ADDITIONAL SHIRTS CAN BE ORDERED ABOVE FOR $10 EACH. **ALL SCHOOL YEAR BALANCES MUST BE PAID IN FULL BEFORE ATTENDING THE SUMMER PROGRAM**

RATES AS FOLLOWS:

RATE	BEST DEAL FULL WEEK = 5 DAYS	4 DAYS	3 DAYS
EARLY BIRD: MAY 1 - MAY 19	$38 DAY / $190 WK	$40 DAY / $160 WK	$42 DAY / $125 WK
REGULAR RATE: MAY 20 - JUNE 9	$40 DAY / $200 WK	$42 DAY / $168 WK	$44 DAY / $132 WK

REGISTRATION: $45 PER CHILD EXTRA TEE SHIRT: $10

DROP-IN RATE: $45 PER DAY
SUBJECT TO AVAILABILITY

CONTRACTS RECEIVED AFTER JUNE 9TH WILL HAVE AN ADDITIONAL $15 PER WEEK LATE FEE
EX: FULL WEEK = $215.00

PARENT 1:_____ PARENT 2:_____
ADDRESS:_____ ADDRESS:_____
EMAIL:_____ EMAIL:_____
PHONE:_____ PHONE:_____
ALT PHONE:_____ ALT PHONE:_____

WEEK	FULL WEEK YES OR NO	MON	TUES	WED	THRUS	FRI	# OF DAYS (3 DAY MIN)	TOTAL PER WEEK (SEE RATES ABOVE)
1 NAILED IT! MAKE AND DECORATE JUNE 26 - JUNE 30	YES NO							$
***** WE ARE CLOSED THE WEEK OF JULY 4TH *****								
2 NERF WEEK JULY 10 - JULY 14	YES NO							$
3 CAMP ADVENTURE JULY 17 - JULY 21	YES NO							$
4 EXPLORING SCIENCE JULY 24 - JULY 28	YES NO							$
5 MARVELS OF MUD JULY 31 - AUG 4	YES NO							$
6 FARM FUN AUG 7 - AUG 11	YES NO							$
7 TROPICAL GETAWAY AUG 14 - AUG 18	YES NO							$
***** WE ARE CLOSED THE LAST WEEK OF SUMMER VACATION *****							GRAND TOTAL:	$

**SIGNATURE OF THIS CONTRACT INDICATES ACKNOWLEDGEMENT THAT PAYMENT IS DUE WHETHER CHILD ATTENDS, OR NOT.
**NO REFUNDS. SUBSTITUTIONS ARE NOT GUARANTEED. PLEASE PLAN CAREFULLY. PLEASE FILL OUT THE REVERSE OF THIS FORM COMPLETELY

COST CALCULATOR

GRAND TOTAL FROM FIRST PAGE _____

REGISTRATION FEE _+_____$45.00__

EXTRA TEE SHIRT (OPT. $10 EACH) _+_____

SUMMER GRAND TOTAL _=_____

SUPPLY LIST: EVERY KID NEEDS EVERYDAY:

- O A WATER BOTTLE
- O GOOD WALKING SHOES
- O A BATHING SUIT
- O SUN BLOCK (PREFERABLY SPRAY ON)
- O A CHANGE OF CLOTHES

POLICIES FOR SKIP'S SUMMER CONTRACTS ARE AS FOLLOWS:

1. OUTSTANDING BALANCES FROM PRIOR ENROLLMENTS MUST BE PAID IN FULL PRIOR TO 2023 SUMMER ENROLLMENT.
2. A NON-REFUNDABLE REGISTRATION FEE OF $45.00 WILL BE PAYABLE UPON ENROLLMENT IN THE PROGRAM. THIS FEE INCLUDES A T-SHIRT THAT MUST BE WORN ON ALL FIELD TRIPS.
3. ALL PROPER ENROLLMENT MATERIALS AND REGISTRATION FEE MUST BE PROVIDED PRIOR TO ATTENDING, EVEN ON A DROP-IN BASIS.
4. ANY NON-CONTRACTED (DROP-IN) ATTENDANCE MUST BE APPROVED BY THE DIRECTOR AT LEAST 24 HOURS PRIOR TO ATTENDING. DROP-IN FEES MUST BE PAID UPON ARRIVAL THE DAY THE SERVICE IS RENDERED.
5. YOU MUST NOTIFY SKIP IF YOUR CHILD WILL BE ABSENT AS SOON AS YOU KNOW (THE DAY BEFORE IF POSSIBLE.) A $20.00 FEE MAY BE ASSESSED IF SKIP IS NOT NOTIFIED OF YOUR CHILD'S ABSENCE ON A CONTRACTED DAY.
6. ONCE YOUR REGISTRATION HAS BEEN ACCEPTED, YOU WILL BEGIN TO RECEIVE YOUR WEEKLY BILLS. THESE MUST BE PAID NO LATER THAN FRIDAY FOR YOUR CHILD TO ATTEND THE FOLLOWING MONDAY.
7. CONTRACTED SERVICES MUST BE PAID REGARDLESS OF ATTENDANCE, AS SPACE WILL BE RESERVED FOR YOUR CHILD.*PLEASE BE SURE TO CONSIDER YOUR FAMILY'S VACATION PLANS BEFORE SUBMITTING YOUR CONTRACT. THERE WILL BE NO REFUNDS. STAFF IS HIRED ACCORDING TO CONTRACTS.
8. SKIP WILL ASSESS A $35.00 LATE FEE FOR BALANCES REMAINING 2 WEEKS PAST DUE, WITH AN ADDITIONAL $25.00 FEE FOR EACH ADDITIONAL WEEK THE BALANCE IS UNPAID.
9. THERE WILL BE A LUNCH SIGN UP FORM TO FOLLOW REGISTRATIONS. IF YOU SIGN YOUR CHILD UP FOR LUNCH AND SEND THEM WITH ONE INSTEAD, THERE IS A $5.00 FEE. WE WILL BE BUYING AND PREPARING THE LUNCHES BASED ON THE AMOUNT OF KIDS SIGNED UP.
10. IF YOU DO NOT SIGN UP FOR A LUNCH AND WE NEED TO PROVIDE YOUR CHILD WITH A LUNCH, THERE WILL BE A $5.00 FEE.
11. A $40.00 FEE WILL BE ASSESSED FOR CHECKS RETURNED FOR INSUFFICIENT FUNDS. PAYMENT IN CASH OR MONEY ORDER WILL BE REQUIRED IF A SECOND BOUNCED CHECK OCCURS.
12. THERE IS A $1.00 A MINUTE PENALTY CHARGE FOR EVERY MINUTE YOUR CHILD IS PICKED UP AFTER OUR CLOSING TIME, WHICH IS 5:30 PM.
13. FAMILIES WITH THE STATE'S CHILDCARE ASSISTANCE ARE RESPONSIBLE FOR THE FULL AMOUNT OF THEIR CHILD'S TUITION. IT IS THE FAMILY'S RESPONSIBILITY TO MEET THE REQUIREMENTS OF THE STATE TO RECEIVE THE SCHOLARSHIP.
14. THE STATE SCHOLARSHIP WILL ONLY HELP COVER HOURS THE CHILD IS IN ATTENDANCE. FAMILIES ARE RESPONSIBLE FOR THE ENTIRE DIFFERENCE BETWEEN OUR RATE AND WHAT IS PAID BY THE STATE.

I/WE HEREBY CONTRACT WITH SKIP'S SUMMER PROGRAM FOR THE SELECTED DAYS. BY SIGNING THIS FORM I/WE AGREE TO ABIDE BY THE FINANCIAL POLICIES OF THIS CONTRACT. THERE ARE NO REFUNDS FOR ANY REASON. I UNDERSTAND THAT IF REKINDLING CURIOSITY FUNDS DO NOT COME THROUGH FOR MY CHILD, I AM LEGALLY RESPONSIBLE FOR PAYING THE BALANCE OF CHARGES REMAINING ACCORDING TO MY SUMMER CONTRACT. THIS IS A LEGAL CONTRACT.

CHILD'S NAME:_____

GUARDIAN SIGNATURE:_____DATE:_____

GUARDIAN SIGNATURE:_____DATE:_____

ADDITIONAL FORMS NEEDED:

1) HEALTH FORM: *DATED WITHIN THE LAST 12 MONTHS IF YOUR CHILD IS 5 YEARS OLD OR YOUNGER OR *DATED WITHIN THE LAST 2 YEARS IF YOUR CHILD IS OVER THE AGE OF 6
2) IMMUNIZATION RECORD
3)A COPY OF YOUR CHILD'S IEP (IF APPLICABLE)

**PLEASE COMPLETE THE ENTIRE PACKET TO FOLLOW (INCLUDING THE CACFP PAPERS AT THE END) MANY OF THE PAGES ARE REQUIRED BY LICENSING. YOUR CHILD CANNOT ATTEND IF WE DO NOT HAVE THEM ON FILE. THANK YOU

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School Kids In Peterborough

CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

(Front)

NAME OF CHILD CARE PROGRAM _____ LICENSE NUMBER 4702

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.

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:
Email:	Email:
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)
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:

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CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

(Back)

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 https://nhlicenses.nh.gov/verification/Search.aspx?facility='Y or by calling the unit at 603-271-9025 or 1-800-852- 3345, extension 9025.

During visits to programs licensing staff speak with children regarding the care they receive at the program if in the judgment of the licensing staff the children's response would be valuable in determining compliance with licensing rules. Licensing staff are experienced in working with children and trained to speak with children in a manner that is respectful and non-leading. Children will remain with their class or group during these conversations with licensing staff, and at no time will a child be forced to speak with a licensing coordinator.

If licensing staff believes your child may have specific information regarding an alleged event at the child care program, and determines that it is best to interview your child separately and not with their class or group, please indicate your preference among the following options:

☐ I give permission for child care licensing staff to interview my child at the child care program separate from their class or group.

☐ I wish to be notified prior to child care licensing staff interviewing my child at the child care program separate from their class or group.

☐ I do not give permission for child care licensing staff to interview my child at the child care program separate from their class or group.

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: 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:

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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:

I_____ (parent Signature)
givepermission to School Kids in Peterborough to use photos of my son(s) or daughter(s),_____
for the purpose of promoting our facility, encouraging volunteers,as well as creating brochures and othe promotional materials, ro for possible publication in a local newspaper or on our websire and facebook connection page. We would never use last names.

☐ I would allow my child's first name to be used
☐ I would prefer no name used for my child(ren)
☐ I do not want my child(ren)s photo used in any way

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Child's Name_____

Operations / Serious injuries:

Chronic or recurring illness:

Dietary restrictions:

Learning Difficulties/behavior issues (have an aide during school?)
☐(check here if yes) Does your child have an IEP/504 plan? If yes, please furnish us a copy. ☐yes ☐no

Physical, Social, Emotional, or Sensory needs:

Activity limitations or special conditions to be watched:

Important, must answer or say N/A

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:_____

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Must check box 1, 2 or 3, an d sign at asterisk

AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

IN ACCORDANCE WITH HE C 4002.18, 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 BE ATTACHED TO THE ORIGINAL PRESCRIPTION CONTAINER.

NON-PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER, AND WILL BE ADMINISTERED IN ACCORDANCE WITH THE MANUFACTURER'S PRINTED INSTRUCTIONS. IF THERE ARE NO MANUFACTURER'S PRINTED INSTRUCTIONS FOR THE AGE OF THE CHILD, THE PROGRAM MAY ADMINISTER THE NON-PRESCRIPTION MEDICATION IN ACCORDANCE WITH THE WRITTEN, DATED AND SIGNED INSTRUCTIONS FROM THE CHILD'S PARENT, INCLUDING A STATEMENT THAT THE INSTRUCTIONS HAVE BEEN REVIEWED APPROVED BY THE CHILD'S 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 (NAME OF CHILD CARE PROGRAM) TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD: _____ (CHILD'S NAME) _____ (DATE OF BIRTH)

1. ☐

NAME OF MEDICATION	DOSAGE (or weight of child)	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE
Tylenol				
Ibuprofen				
Benedryl				

or

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:

2. ☐ call me first at _____ (phone number)

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

or

_____ _____

LICENSED HEALTH PRACTITIONER'S SIGNATURE — DATE SIGNED

3 ☐ **not authorize ANY administration of medication to my child while at SKIP**

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

Note:For prescription medications, a licensed health care practicioner must fill this form out and aign it.

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

_____ _____

SIGNATURE AND POSITION TITLE OF PERSON SUPERVISING ADMINISTRATION CONTROL OF MEDICATION — DATE SIGNED

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 and Adult Food Program Paperwork (above and to follow:) MUST BE FILLED OUT AND RETURNED AS MARKED OR YOU WILL INCUR A $10.00/WEEK SURCHARGE

August 2020
ccc/fdch Income Eligibility Form

SKIP is part of the CACFP (Child and Adult Food Program) This is a federal program that reimburses us a small amount of money for each snack and meal we serve the children. We must follow strict program guidelines on quality and quantity of food we serve, (such as 100% juice, etc), and we are subject to periodic monitoring visits. Our staff has special training through this program in how to best serve your children age appropriate, nutritious snacks and meals. It uses the same paperwork for free and reduced lunch.

We need every family to fill these forms out! It is not optional.
We want to use this reimbursement to plan, buy, and serve the best foods for your child!

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (CHILD CARE/FDCH)

PART 1. ALL HOUSEHOLD MEMBERS

Names of all household members (First, Middle Initial, Last)	Name of each child's school /or indicate "NA" if child is not in school	Place a check in the box below if child is a foster, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster, homeless, runaway, migrant or in Head Start, skip to part 4 to sign this form.					Place a check in the box if NO income
		Foster	Homeless	Migrant	Runaway	Head Start	
*							

PART 2. BENEFITS: If any member of your household receives SNAP or TANF ASSISTANCE, provide the name and case number for the person who receives benefits and skip to part 4. if no one receives these benefits, skip to part 3.

NAME:_____ PROGRAM NAME _____ CASE NUMBER:*(NOT EBT CARD#)* _____

PART 3. TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS). List all income on the same line as the person who receives it. Check the box for how often it is received. RECORD EACH INCOME ONLY ONCE.

1. Name ** (list only household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED																			
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Social Security, SSI, VA, retirement benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All other income (such as Unemployment) benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	$200	X				$150		X			$0					$0				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				
	$					$					$					$				

PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN): An adult household member must sign the application. **If Part 3 is completed, the adult signing the form also must 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 Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: _____ Print name:_____

Date: _____

Address:_____ City:_____ State:_____ Zip Code: _____

Phone Number:_____

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

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PLEASE FILL OUT THIS PAGE AND PAGE 11 OUT COMPLETELY - BUT ONLY WHERE THERE IS AN ASTERISK *

IF YOU DO NOT QUALIFY PER THE INCOME CHART ON PAGE 10, YOU MAY WRITE "OVERQUALIFIED" IN THE BOX WITH TWO ASTERISK (**) ABOVE

PART 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:	*Choose one or more (regardless of ethnicity):*		
❑ Hispanic/Latino	❑ Asian	❑ American Indian or Alaska Native	❑ Black or African American
❑ Not Hispanic/Latino	❑ White	❑ Native Hawaiian or other Pacific Islander	

Your children may qualify for free or reduced price meals if your household income falls at or below the limits on this chart.

FEDERAL ELIGIBILITY INCOME CHART For School Year **2020-2021**

Household size	Yearly	Monthly	Weekly
1	$23,606	$1,968	$454
2	31,894	2,658	614
3	40,182	3,349	773
4	48,470	4,040	933

Household size	Yearly	Monthly	Weekly
5	$56,758	4,730	1,092
6	65,046	5,421	1,251
7	73,334	6,112	1,411
8	81,622	6,802	1,570
Each additional person	$ 8,288	$ 691	$ 160

DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY.

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: _____ Eligibility: Free____ Reduced____ Denied____ Date Withdrawn: _____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Verifying Official's Signature: _____ Date: _____

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 your child 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 last four digits of 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

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.

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Child and Adult Care Food Program

CHILD ENROLLMENT FORM

Dear Parent:

Your child(ren)'s child 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 in attendance. This program reimbursement supports the quality of the meal program and is beneficial to you and your child(ren) because it provides nutritious meals and snacks.

Sponsoring Organization Name: **Southern NH Services, Inc**
Sponsoring Organization Phone #: **(603) 668-8010**
Child Care Provider/Business Name:

Sponsoring Organization CACFP
Representative Name: **Amy Allen**

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.***

→ SKIP will do.

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

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 to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.*

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