Welcome to Westbay Community Action Children's Center!

We are delighted that you chose our program as your child's guide to early childhood education. We know how much time and care you put into making this important decision. We assure you that we will provide your child with the very best education, care *and* nurturing environment he/she will need to grow and develop successfully at our Center.

At **Westbay Children's Center** we pride ourselves in providing a leading early care and education program for infants, toddlers, and preschool children. In the setting of an early care and education center, our commitment is to foster the growth and development of each child through enriching and stimulating experiences that are geared to their specific age level and stage of development.

Our center is composed of separate age-based classrooms where children engage in a creative and thematic approach to their early childhood learning. We operate with a dual license from the *Department of Education* and the *Department for Children Youth and Families*. Westbay Children's Center adheres to both of these state departments' regulations.

In a classroom environment that is happy and secure, the educational staff provides a setting where your child is free to develop and learn at his-her own rate. Our education programs consist of developmental and cognitive activities which will enable each child to grow to their fullest potential. We provide diagnostic screenings, with parental consent, to help in planning an individual educational program for each child.

We believe that parents play a vital role in the total operation of our school. The input and support of parents in our center is crucial in helping foster the quality of our programs and in establishing positive relationships with you. These positive attitudes enhance and strengthen our program and your child's ability to adjust outside the home.

Our operating hours are **Monday through Friday from 7am to 5:30pm**. Our center is closed for all major holidays, two of which are half days, and two professional days.

Payments are due on Friday prior to the week of care. Payments may be in the form of cash, check, or credit card (Visa, MasterCard or debit). Bi-weekly or monthly payments must be paid in advance of services. If you would like your credit card billed automatically each week, forms are available in our office.

Finally, if you have any questions, please do not hesitate to ask **Debbie Rapa** (Education Coordinator), **Kahree Paolantonio** (Administrator), or your child's teacher!

Don't forget to like our page on Facebook and ask for access to our ClassTag application for school announcements, events, and updates on your child's day!

Westbay Children's Center

2023 Holiday Schedule

We are closed for all major holidays and two professional days each year. Our 2023 holiday closures are:

New Year's Day	Friday	1/2/23
Martin Luther King Jr. Day	Monday	1/16/23
Presidents' Day	Monday	2/20/23
Professional Development	Friday	5/19/23
Memorial Day	Monday	5/29/23
Juneteenth (observed)	Monday	6/19/23
Independence Day (observed)	Tuesday	7/4/23
Victory Day	Monday	8/14/23
Professional Development	Monday	8/28/23
Labor Day	Monday	9/4/23
Columbus Day	Monday	10/9/23
Veterans' Day (Observed)	Friday	11/10/23
Thanksgiving Day	Thursday	11/23/23
Day after Thanksgiving	Friday	11/24/23
Christmas Eve (Observed) Half Day	Friday	12/22/23
Christmas Day	Monday	12/25/23
New Year's Eve (Observed) Half Day	Friday	12/22/23
New Year's Day	Monday	1/2/24

Westbay Children's Center

Family Events Calendar 2022-2023

September

S	M	T	W	Th	F	S
		30	31	1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

8/30 - First Day of School
9/5 - Closed for Labor Day
9/9-Grand Breakfast
9/11- Grandparent's Day
9/21- Open House
9/23- Fall Picture Day

TBD- Catalog Fundraiser

October

S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

10/10- Closed for Columbus Day
10/22- Trunk or Treat
10/24-10/28 Infant Parent/ Teacher Confrences
10/24- Diwali
10/31- PJ Day for Halloween

November

S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

10/31-11/4- Toddler Confrences
11/7-11/11- Preschool Confrences
11/11- Closed for Veterans Day
11/14-11/18- Pre K Confrences
11/23- Family Feast
11/24-11/25- Thanksgiving Recess

December

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

12/16- Pajama Day
12/18- First Day of Hanukkah
12/23- Close at 12:00
12/25- Christmas Day
12/26- Closed for Christmas
12/30- Close at 12:00

TBD- Santa Visting!

January

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

1/2- Closed for New Year's Day
1/16- Closed for MLK Day

February

S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28				

2/2- Groundhog's Day
2/14- Valentine's Day
2/20- Closed for President's Day

TBD- Cookie Dough Fundraiser

March

S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

3/6-3/10- Infant Confrences
3/13-3/17- Toddler Confrences
3/20-3/24- Preschool Confrences
3/22- Ramadan Begins
3/22- Spring Picture Day
3/25 Bunny Trail Family Event
3/27-3/31- Pre K Confrences

April

S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

4/9- Easter
4/17-4/21- Week of the Young Child

May

S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

5/1-5/5- Teacher Appreciation Week
5/12- Muffins in the Morning
5/14 - Mother's Day
5/19- Closed for Professional Development
5/29- Closed for Memorial Day

June

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

6/9- End of the Year Cookout Celebration
6/16- Donuts with Grownups
6/18- Father's Day
6/19- Closed for Juneteenth

July

S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

7/4- Closed for Independence Day

August

S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

8/14- Closed for Victory Day
8/28- Closed for Professional Development

Westbay Children's Center

Tuition Rates

Tuition is charged to accounts weekly and payments are due by the end of business hours on Friday for the following week of care

Infants (6 weeks – 18 months)

# of Days	
5 days	$275
4 days	$250
3 days	$220

Toddlers (18 – 36 Months)

# of Days	
5 days	$240
4 days	$220
3 days	$200

Preschool & Pre-K

# of Days	
5 days	$210
4 days	$195
3 days	$180

Effective as of: 9/1/2021

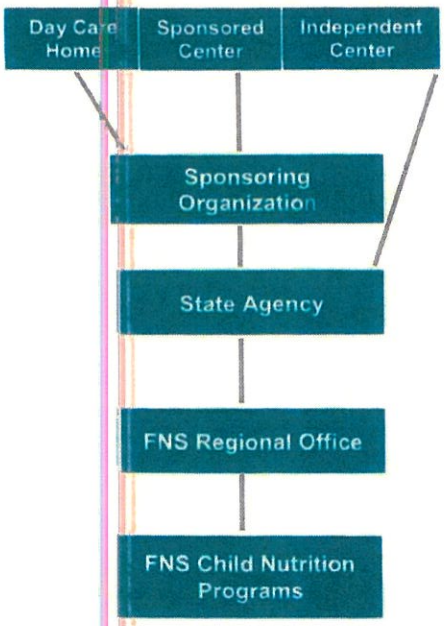
How does CACFP work?

Day care homes and centers receive money for serving nutritious meals. The Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA) oversees CACFP.

States approve sponsors and centers to operate the program. States also monitor and provide training and guidance to make sure CACFP runs right.

Sponsoring organizations support day care homes and centers with training and monitoring. All day care homes participate in CACFP through a sponsor.

CACFP Partners



Contacts

Here is space for the State agency and sponsoring organization to add contact information.

USDA

FNS-319
October 2019

Building for The Future

In the Child and Adult Care Food Program (CACFP)

Building for the Future in the CACFP

What is CACFP?

CACFP is the Child and Adult Care Food Program. It is a Federal program that pays for healthy meals and snacks for children and adults in day care.

CACFP improves the quality of day care. It makes the cost of day care cheaper for many low-income families.

Besides providing meals in day care, CACFP makes afterschool programs more appealing to at-risk children and youth. Serving afterschool meals and snacks attracts students to learning activities that are safe and fun.

Children and youth who are homeless can also receive meals at shelters that participate in CACFP.

Here is space for the State agency and sponsoring organization to add contact information.

Who is eligible for CACFP meals?

- Children under age 13,
- Migrant children under age 16,
- Children and youth under age 19 in afterschool programs in low-income areas,
- Children and youth under age 19 who live in homeless shelters, and
- Adults who are impaired or over age 60 and enrolled in adult day care

What kinds of meals are served?

CACFP meals follow USDA nutrition standards.

- Breakfast consists of milk, fruits or vegetables, and grains.
- Lunch and Supper require milk, grains, meat or other proteins, fruits, and vegetables.
- Snacks include two different servings from the five components: milk, fruits, vegetables, grains, or meat or other proteins.

Where are CACFP meals served?

Many types of facilities participate in CACFP.

Child Care Centers:
Licensed child care centers and Head Start programs provide day care with meals and snacks to large numbers of children.

Outside-School-Hours Care Centers:
Licensed centers offer before or afterschool care with meals and snacks to large numbers of school-aged children.

Family Day Care Homes:
Licensed providers offer family child care with free meals and snacks to small groups of children in private homes.

"At-Risk" Afterschool Care Programs:
Centers in low-income areas provide learning activities with free meals and snacks to school-age children and youth.

Emergency Shelters:
Homeless, domestic violence, and runaway youth shelters provide places to live with free meals for children and youth.

Adult Day Care Centers:
Licensed centers provide day care with meals and snacks to enrolled adults.

U.S. Department of Agriculture

WOMEN, INFANTS, AND CHILDREN PROGRAM (WIC)

- Pregnant or postpartum women, infants, and children up to age 5 are eligible for WIC.

- You must live in RI, and be individually determined to be at "nutritional risk" by a health professional,

AND

- You must meet income guidelines.
  - A person or certain family members automatically meets the family income eligibility requirements by participating in Supplemental Nutrition Assistance Program (SNAP), Medicaid, or RIWorks

Or

  - Your gross income (before taxes are withheld) must fall at or below 185 of the U.S. Poverty Income Guidelines:

WIC Income Eligibility Guidelines
(Effective from July 1, 2022 to June 30, 2023)

Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	25,142	2,096	1,048	967	484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
Each add'l member, add	$8,732	$728	$364	$336	$168

This institution is an equal opportunity provider.

What are the benefits?

WIC participants receive:

- Supplemental Nutritious foods
- Nutrition education and counseling at WIC clinics
- Screening and referrals to other health, welfare and social services

In RI, WIC participants receive WIC checks to purchase specific foods each month which are designed to supplement their diets. WIC foods include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, vitamin C-rich fruit and/or vegetables juice, eggs, milk, cheese, peanut butter, dried beans or peas, tuna fish and carrots. Special infant formulas and certain medical foods may be provided when prescribed by a physician or health professional for specified medical condition.

Below is the RI WIC website
http://www.health.ri.gov/programs/wic/
Or
Call for information on sites near you.

Telephone:	(401) 222-4623
Toll free (in-state):	1-800-942-7434
TDD:	1-800-745-5555

WESTBAY CHILDREN'S CENTER APPLICATION FOR ENROLLMENT

APPLICANT INFORMATION

Child's Name:

Date of birth:	**SSN:**

PARENT OR GUARDIAN 1

Guardian 1's Name:

Phone:
Email:
Street Address:
City/ State/ Zip Code:

Employer:
Work Schedule:
Work Phone:

PARENT OR GUARDIAN 2

Guardian 2's Name:

Phone:
Email:
Street Address:
City/ State/ Zip Code:

Employer:
Work Schedule:
Work Phone:

QUESTIONS

How did you hear about our program?

Is your child transferring from another program? If so, why?

Has your child attending preschool before? If so, where?

CIRCLE THE DAYS YOUR CHILD WILL BE ATTENDING

Monday Tuesday Wednesday Thursday Friday

Hours your child will be attending:

Start Date:

SIGNATURE

I CERTIFY THAT THE INFORMATON PROVIDED IN THIS APPLICATION IS TRUE

Signature of Parent or Guardian: _____ **Date:**_____

Westbay Children's Center

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AUTHORIZATION FOR RELEASE

westbay community action
Helping people. Changing lives.

Child's Name: _____ Date: _____

Our security door requires a 4-digit code to gain entry to our school. Please indicate your 4-digit code below and list the people that you authorize to pick up your child(ren) from our school. By listing a person here, **you are authorizing Westbay Children's Center to release your child to that person at any time.** Each escort can have their own pin # to enter to the school. However, access to the school should only be given to close family members/friends on this list. We also encourage you to select a one-word phone code for security purposes. You may be asked for your code to verify that it is you calling to authorize a pickup change. You may add or delete names at any time. Please see an office staff member to do so. Thank you for your cooperation with this important school policy.

Legal Guardians

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship to Child: _____ Relationship to Child: _____

Special Instruction: _____ Special Instruction: _____

Authorized Escorts

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship to Child: _____ Relationship to Child: _____

Special Instruction: _____ Special Instruction: _____

Name: _____ Name: _____

Phone Number: _____ Phone Number: _____

Relationship to Child: _____ Relationship to Child: _____

Special Instruction: _____ Special Instruction: _____

Phone Code:(so we can identify you when you call with instructions): _____

- Any change of escorts must be made in writing by the enrolling parent/guardian
- It is the enrolling parent's responsibility to provide copies of legal notices to the center (i.e. Custody Orders, Restraining Orders, etc.)
- All escorts must provide a photo identification at the front office before your child is released
- Please sign to indicate you have read and understand this policy.

Signature: _____ Date: _____

AUTHORIZATION FOR EMERGENCY TREATMENTS

I hereby authorize Westbay Children's Center to arrange for medical examination and/or treatment of my child _____ should an emergency arise at school or on a field trip. It is understood that a conscientious effort will be made by the school to contact me at the emergency numbers I have provided before any medical action is taken. (If the need arises), I would prefer to have my child _____ taken to _____ Hospital. (Note: choice of hospital may be limited by service of local rescue and/or hospital availability.)

In addition, if your child has a medical emergency at Westbay Children's Center or on a field trip, we would like to be fully informed regarding the medication your child is currently taking.

Please list any prescribed medications, including the ones taken at home. Should this information change, please keep us informed so we can keep our records up to date.

Thank you

MEDICATIONS

Child's Name:	Date:		
MEDICATION	**REFILLS**		
Medication Name	Times	Time/s Given	Dose

Signature of Parent/Guardian _____ Date _____

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Photo Permission

I, _____, understand that by enrolling my child, _____I grant Westbay Children's Center permission to have photographs and / or videos taken during different activities and field trips at / with Westbay Children's Center. Photo/videos may be used in the classroom and on our parent engagement /communication app, ProCare.

_____ _____

Parent/Guardian Signature Date

Website / Social Media / Facebook Permission

I, _____, give permission for my child's photographs/videos to be used on the Westbay Children's Center Social Media (Facebook),News Media (i.e. Newspaper, television) and center website, www.westbaychildrenscenter.com.

_____ _____

Parent/Guardian Signature Date

Sunscreen Permission

I, _____, give permission for staff of Westbay Children's Center to re-apply sunscreen to my child throughout the school day as necessary.

_____ _____

Parent/Guardian Signature Date

HEALTH HISTORY OF CHILD

Child's Name: _____

Do you have medical coverage for your child? _____
Name of Medical Coverage: _____ Coverage #: _____

Name of child's physician: _____ Date of last visit: _____
Address: _____ Phone #: _____

Name of Dentist: _____ Date of last visit: _____
Address: _____ Phone #: _____

Does your child have any allergies? Yes____ No_____ If so list and sign permission for it to be posted in the classroom _____
All allergies must be listed on your child's physical, or a doctor's note must be provided
Signature: _____ Date: _____

Has your child had any childhood illnesses/diseases? _____ If so, please list all types and dates:
_____

Does your child have any handicaps or special needs? _____ If so, please describe:
_____

Does your child take medication on a regular basis? _____ If so, list below:

Name of Medication	Daily Dosage	Name of Medication	Daily Dosage

Has your child ever been hospitalized? _____ If so, list reason:

Reason for hospitalization	Date of Admission	Length of Stay

Is there anything "special" we should know about your child which would help in caring for them?_____
_____
_____

Signature of Parent/Guardian _____ Date _____

Westbay Children's Center

School Name & Address: Westbay Children's Center, 22 Astral St. Warwick, RI 02888

Grade: _____

STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap/Td ≥ 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

Medical Exemption:

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ___/___/___ Height _____ Weight _____ BP _____

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

1. ASTHMA No☐ Yes☐ If yes, complete an *Asthma Action Plan* (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)
2. ALLERGIES: No☐ Yes☐ (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No☐ Yes☐

If student has a severe allergy (food, insect, other) complete a *Food Allergy & Anaphylaxis Emergency Care Plan* (www.foodallergy.org/document.doc?id=234)

3. DIABETES: No☐ Yes☐ If yes, complete a *Physicians Order Form For Students With Diabetes* (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)
4. OTHER _____

Treatment Plan: _____

RESTRICTIONS: Can participate in physical education/sports: Fully☐ With limitation☐ _____

MEDICATION (REQUIRED AT SCHOOL): No☐ Yes☐ (Please list) _____

Other medication(s) that may affect behavior or health at school _____

LEAD SCREENING (Required for children < 6 years old) Student is in compliance with lead screening requirements Yes☐ No☐	SCOLIOSIS SCREENING Yes☐ No☐	VISION SCREENING (Children entering Kindergarten) ☐ Passed Screening ☐ Screened & referred for comprehensive exam ☐ Referred for comprehensive exam, but not screened
TUBERCULOSIS (If required by school district) Date of TB test:		Screening / Referral Date: Comprehensive Exam Date:

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PUPIL INFORMATION FORM

We are interested in meeting the needs of your child. This additional information will help us achieve this goal and devise a more individual program from your child.

Child's Name_____ Date of Birth_____
Name your child responds to (nickname)_____
Favorite Toy_____
Is there a special friend or playmate? _____ Name_____
Do you have any pets? _____ Type and name(s)_____

SLEEPING

1. What time does your child usually go to bed at night? _____
2. Get up in the morning? _____
3. Does your child sleep with a special toy or security blanket? _____
4. Does your child usually nap or rest during the day?_____ for how long?_____

SPEECH/LANGUAGE

1. What is the primary language spoken at home? _____
   If English is not your primary language, does your child understand English? _____, Speak English?
   _____
2. Does your child speak clearly so that others can understand them?
3. Do you have any concerns about your child's speech or language development? (If so, please specify) _____

SELF HELP

1. Can your child dress themselves? _____ Manage Buttons? _____ Zippers? _____
2. Does your child tell an adult when they need to go to the bathroom? _____
   Child's words for urination_____ bowel movement _____

SOCIAL/EMOTIONAL

1. Does your child have any particular fears? _____ (If so, specify) _____
2. Have any of the following issues recently occurred in your family?
   ___ serious family illness ____ death of a loved one ____ death of a pet
   ___ separation or divorce____ new home _____ birth of a sibling
   ___ other (specify)_____
3. How would you characterize your child (check all that apply) ___assertive ___aggressive ___shy ___withdrawn ___a leader ___ a follower ___plays alone ___ seeks others
4. Are there any activities common to your child's age group that your child has no apparent interest in? _____

OTHER

1. What holidays or cultural celebrations does your family celebrate? _____
   _____
2. Are there any celebrations that you object to? (specify)_____
3. Is there any other information we should have to help plan for your child?
   _____

Westbay Children's Center

INTEREST/LEARNING STYLES SURVEY

CHILD'S NAME: _____ **DATE:** _____

GUARDIAN(S) NAME: _____

WHAT ARE YOUR CHILD'S INTERESTS?

HOW DOES YOUR CHILD LEARN BEST (PLEASE CHECK)

___VISUALLY: (PREFERS PICTURE BOOKS, ENJOYS DRAWING AND CREATING; GOOD SENSE OF DIRECTION; REMEMBERS FACES)

___PHYSICALLY: (TOUCHES AND MANIPULATES NEW OBJECTS; LIKES TO RUN, WALK, JUMP, HAS A DRAMATIC WAY OF EXPRESSING SELF)

___MUSICALLY: (REMEMBERS SONGS; HUMS AND SINGS TO SELF; LOVES TO PLAY INSTRUMENTS)

___SOCIALLY: (GETS ALONG WITH MOST EVERYONE; ENJOYS GROUP ACTIVITIES; NATURAL LEADER)

___SOLITARY: (STRONG WILLED; INDEPENDENT; DOES NOT TAKE RISKS; ENJOYS PLAYING AND READING ALONE.

___VERBALLY: (ENJOYS SHARING KNOWLEDGE; GOOD VOCABULARY; GOOD MEMORY FOR NAMES AND PLACES)

___LOGICALLY: (PLACES ITEMS IN ORDER; ENJOYS CREATING PATTERNS; ASKS QUESTIONS ABOUT HOW THINGS WORK; ADVANCED MATH SKILLS FOR AGE)

WHAT DO YOU FEEL IS IMPORTANT FOR YOUR CHILD TO LEARN IN PRESCHOOL OR KINDERGARTEN?

KIDS CONNECT

CONSENT TO PARTICIPATE

Dear Parents,

We partner with the Executive Office of Health & Human Services in Rhode Island to provide Kids Connect in our program. This program allows us to provide the extra support needed for every child to successfully navigate our program.

Through this partnership, we are able to provide a Therapeutic Integration Specialist (TIS) and a clinician in your child's classroom. Our clinician prepares an individualized plan for successful integration into our program and works with our staff to support the needs of each child.

Based on classroom observations, previous experiences, developmental concerns, social or emotional concerns, or referrals from outside agencies, we may identify that your child could benefit from additional support. In the event that it becomes necessary, we would plan to meet with you to discuss your child's participation in this program.

We ask each family to sign this form to show that you understand the benefits of this program and would be willing to consider participation if needed.

If you have any concerns or questions, please contact Deborah Rapa at 401-463-6620.

Should the need arise, I understand the Kids Connect program as described above. I agree to begin the process for my child to participate in Kids Connect.

_____ _____

Child's Name Date

_____

Print Name

_____ _____

Parent/Guardian Signature Date

For office use: Referral _____ IEP _____ IFSP_____ Past Exclusion____

Westbay Children's Center

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CREDIT CARD AUTHORIZATION FORM

I AUTHORIZE WESTBAY COMMUNITY ACTION, INC. TO CHARGE MY INVOICES TO MY CREDIT CARD. WESTBAY COMMUNITY ACTION, INC. OR I MAY TERMINATE THIS AGREEMENT BY WRITTEN NOTICE FROM EITHER PARTY TO THE OTHER.

CARDHOLDER'S INFORMATION	
Cardholder's Name	
Cardholder's Home Address	
Cardholder's Billing Address	
Cardholder's Email for receipt	

CREDIT CARD INFORMATION	
Card #	
Expiration Date	
Security Code	
Type of Card	Master Card _____ VISA_____ Other _____

SIGNATURE & DATE OF CARDHOLDER	
Signature	
Date	

PAYMENT INFORMATION (to be completed by office staff)	
Child's Name	
Weekly Charge	

Parent/Provider Enrollment Agreement

Rev. 2/2020

Rhode Island Department of Human Services
Office of Child Care
25 Howard Avenue, LP Bldg. 3rd Floor
Cranston, R.I. 02920
(401) 462-6877

This form is to be used by the parent and the provider when enrolling a CCAP eligible or potentially eligible child at an approved DHS provider. One form must be completed per enrolled child. It must be completed and signed by the parent **and** the child care provider; a copy is to be kept by both parties. It is the **provider's responsibility** to submit this information to DHS via the Provider Portal **BEFORE** the provider begins caring for the child. Once the enrollment is complete, the parent and the provider will receive an Enrollment notice.

Provider ID:	**Provider Name:**		
Parent's Full Name:		**Certificate Number:**	
Child's Full Name:		**Child's DOB:**	

Are you related to the child? __ Yes / __ No

AGREED HOURS OF CARE					
Care Start Date: Care End Date:				Use this section when child's schedule is a split day	
Day	Start Time	End Time		Start Time	End Time
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

The undersigned Provider, hereafter referred to as "Provider" agrees to care for the above-named child for the period indicated in this enrollment. Provider further agrees that the days and times the child will attend were agreed upon by the Provider and the undersigned parent of the child. **The undersigned parent certifies that the hours of this enrollment correspond to the hours DHS Authorized hours.**

The Provider agrees to accept the DHS payment based upon the DHS authorization and approval for Full Time, Three Quarter Time, Half Time, Quarter Time or Before and/or After School Care as payment in full and understand that any services provided in excess of authorized hours shall be the sole responsibility of the parent. Provider understands and agrees to accept this payment in accordance with DHS rules and regulations lawfully promulgated in accordance with R.I. General Laws. The Provider agrees to provide child care in accordance with the DHS rules and regulations and in accordance with the DHS CCAP Approved Provider Agreement.

The undersigned parent agrees to pay his/her share of the child care cost in accordance with the RI DHS rules and regulations and specified in the notice sent by the RI DHS Child Care Assistance Program.

The Provider and the undersigned parent certify that they DO NOT live in the same household.

Signature of Parent _____ **Date** _____

Signature of Provider _____ **Date** _____

Provider Printed Name _____ **Position/Title** _____

Important Health Reminder

Revised 1/2023

Dear Parents and/or Guardians,

We have updated our health policy, we wanted to update you on our illness/exclusion policy. The childcare provider, not the child's family, makes the final determination about whether the child can receive care in the childcare program. If your child presents ill with any of the illnesses listed above, you will be contacted immediately. From the time of contact, you will have **one hour** to pick your child up. We appreciate your efforts in limiting the risk of transmission.

Please keep your child home for any of the following:

1. **Fever** of 100.4 or above.
2. **Diarrhea** or loose stools, or increased frequency of stool that cannot be contained. Children may be allowed to return to childcare once the diarrhea has resolved.
3. **Vomiting** illness (2 or more episodes in the previous 72 hours), until vomiting has resolved or until a health care provider determines that the cause of vomiting is not contagious.
4. **Behavior changes** along with **1 or more additional symptoms of illness**
5. **Consistent cough** not accompanied by a doctors note
6. **Mouth sores** with drooling, until a healthcare provider determines the child is non-infectious.
7. **Rash with fever or behavioral changes** until a physician determines the rash is not contagious.
8. **Pink eye** (Conjunctivitis) with white or yellow eye drainage, until the child has been on antibiotic ointment or eyedrops for 24 hours. Please bring a note from your doctor.
9. **Head lice or nits** (lice eggs) the child may return after the first treatment and when no nits or lice are visible in the hair.
10. For **Scabies,** the child will be excluded until treatment has been completed.
11. **For any other contagious illness such as strep throat, chickenpox, whopping cough (pertussis), mumps, hepatitis A, measles, rubella, Flu, COVID19, other respiratory tract illness etc.**

    DHS and DOH will be notified of any positive COVID19 diagnosis

    Children need to be symptom free from all the above for 72 hours unless there is a doctor's note clearing them.

Please bring in a note from your physician clearing your child to return from **any serious illness** or if treatment has been prescribed.

If traveling outside of the state, please contact the Childcare Administrator or Education Coordinator for the current guidelines on COVID-19 and testing requirements in order to return to care. Please note that as stated in your financial agreement and parent handbook, tuition is due regardless of whether your child attends the center or not. There will be no exceptions.

**If the childcare staff is uncertain about whether the child's illness poses an increased risk to others, the child will be excluded until a physician or nurse practitioner notifies the childcare program that the child may attend. **

We understand that our families need to work, but we will strictly enforce the above policy to reduce the amount of illness that circulates through the building. We do sanitize toys, tables, chairs, etc., regularly, but everyone's cooperation in following the above policies is critical in preventing illness from spreading.

Thank you for your understanding. Please sign and return the attached form acknowledging receipt of this letter. Keep this page for your reference.

I have read and agree to the attached reminder regarding Westbay Children's Center's **Illness and Exclusion Policy** (updated as of 1/2023) I understand that the childcare provider, not the family, makes the final determination about whether the child can receive care in the childcare program.

My Child's Name:_____

Classroom:_____

My Signature:_____

Please Print Name:_____ Date:_____

This form will be kept in your child's record as a receipt of the Health Policy.

Westbay Community Action, Inc.
TRACKER INTAKE FORM

Complete_____ Incomplete_____

Date Returned to DD_____

Social Security Number	Date of Service	Site Code	Staff Code	Service Code (s)

Last Name	MI	First Name	DOB (M/D/Y)	Head Y/N	Relation

Street Address	City	Zip Code	Phone Number
			(H)
			(C)

Gender
- ☐ Female
- ☐ Male

Disabled
- ☐ Yes
- ☐ No

Eth. Background
- ☐ White
- ☐ Black
- ☐ Native American
- ☐ Hispanic
- ☐ Asian/Pac. Isl
- ☐ Aleut
- ☐ Eskimo

Food Stamps/SNAP
- ☐ Yes $_____
- ☐ No

Veteran
- ☐ Yes
- ☐ No

Farmer
- ☐ Yes
- ☐ No

Primary Lang.
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Portuguese
- ☐ Cambodian
- ☐ Laotian
- ☐ Other_____

Health Insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ Private:_____
- ☐ Self Insured
- ☐ Rite Cure
- ☐ Other_____
- ☐ No Insurance

Household Information

Number in Family_____

Household Type
- ☐ Single Parent Female
- ☐ Single Parent Male
- ☐ Two Parent
- ☐ Single Person
- ☐ Couple
- ☐ Foster
- ☐ Other_____

Marital Status
- ☐ Single
- ☐ Separated
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Education
- ☐ 0-8
- ☐ 12+
- ☐ 9-12
- ☐ College
- ☐ HS Grad / GED

Source of Income
- ☐ Employment
- ☐ Unemployment
- ☐ Social Security
- ☐ TANF/RI Works
- ☐ GPA
- ☐ SSI / SSDI
- ☐ Pension
- ☐ Disability
- ☐ Other_____

Frequency of Income
- ☐ Weekly _____
- ☐ Bi-Weekly_____
- ☐ Monthly _____
- ☐ Quarterly _____
- ☐ Annually _____

Total Mthy. Income from all Sources

$_____

Housing Status
- ☐ Home Owner
- ☐ Rental
- ☐ With Family
- ☐ Subsidized Rental
- ☐ Homeless with Roof
- ☐ Homeless without Roof
- ☐ Living with Friends relatives
- ☐ Shelter
- ☐ Mthy. Payment$_____

Other Household Members

Name	Social Security	Rel	DOB	Gender	Educ.	Eth	Income	SVC Code	Date

Did you file a Tax return? Y/N If yes, did you receive a EITC tax credit? Y/N

WCA Staff_____ Date_____

Client Signature_____ Date_____

CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care home or center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us at:

Westbay Children's Center

Step 1:

List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes,* mark the correct boxes next to the child's name and go to Step 4.

Step 2:

You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

How do you report income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write *0* in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children don't have to be U.S. citizens to qualify for meal benefits.
You are in the military	Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

CACFP Meal Benefit Income Eligibility Form
Sharing Information with Medicaid and SCHIP

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to*. Medicaid and SCHIP *only* use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

☐ **No! I do not** want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Today's Date: _____

Print Your Name: _____

Address: _____

Signature of Parent or Guardian: _____

If you have questions or need help, please contact **Kahree Paolantonio** at **401-463-6620** or **kpaolantonio@westbaycap.org**.

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility Form
Letter to Parents (Non-Pricing Centers)

7/1/22

Dear Parent or Guardian**:**

Westbay Children's Center offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). **Westbay Children's Center** receives support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2022 - June 30, 2023		
Household size	Yearly Income	Monthly Income
1	$25,142	$2,096
2	33,874	2,823
3	42,606	3,551
4	51,338	4,279
5	60,070	5,006

Please fill out a *CACFP Meal Benefit Income Eligibility* form. It will help us find out how much support **Westbay Children's Center** receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please send the completed form to:

Westbay Children's Center, 22 Astral Street, kpaolantonio@westbaycap.org

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability. If you have questions or need help, please contact **Kahree** at **401-463-6620** or **kpaolantonio@westbaycap.org**.

Sincerely,

Kahree Paolantonio, Administrator

This institution is an equal opportunity provider.

PROMOTING ACCESS TO VOTING:

Visit https:vote.gov to find more information about local, state, and federal elections and how you can participate.

Check Voter Registration Deadlines and Laws in Your State | Vote.gov

Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.
Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups:)
Milk	Milk	Milk
Fruit or Vegetable	Meat or meat alternate	Meat or meat alternate
Grains	Grains	Grains
	Fruit	Fruit
	Vegetable	Vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under
- Migrant children age 15 and younger, and
- Youths through age 18 in afterschool care programs in needy areas

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

Westbay Children's Center

Child Nutrition Programs
RI Department of Education
255 Westminster Street
Providence, RI 02903
(401) 222-4600

USDA Nondiscrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Updated 5/19/22

Child and Adult Care Food Program (CACFP)

Day Care Center Child Enrollment Form

The Westbay Children's Center day care center participates in the U. S. Department of Agriculture Child and Adult Care Food Program (CACFP). This program helps us provide nutritious meals and snacks to children enrolled at our center. The requirements and portion sizes for those meals and snacks are included as an attachment to this enrollment form. Under the regulations of the CACFP, you are not charged separate fees for meals nor may you be asked to provide food for your children for those meals or snacks claimed under the program. Regular day care fees cover the cost of care and food costs not reimbursed by the CACFP.

Check here ONLY if you are choosing **not** to enroll your child in CACFP, then sign and date the bottom of the form:

☐ *I do not want my child to participate in the Child and Adult Care Food Program (CACFP)*

To verify the enrollment of your child in this child care center complete the following information, sign and date the bottom of the form and return it to the day care center:

Day Care Center's Name: Westbay Children's Center

Your Child's Name: ______ ______ ______ ______

Last Name First Name Month, Date & Year of Birth Age

First Day of Attendance: ______

My child will normally be in child care during the following days and times and receive the meals as indicated below:

Normal day of care (check each applicable day)	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
Normal hours in care (indicate AM or PM)	____ To ____ And ____ To ____	____ To ____ And ____ To ____	____ To ____ And ____ To ____	____ To ____ And ____ To ____	____ To ____ And ____ To ____
Meals normally served to my child	☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack	☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack	☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack	☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack	☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Parent/Guardian Name (Please Print): ______

Address (Please Print): ______

Work Phone: ______ Home Phone: ______

Parent/Guardian Signature: ______ Date: ______

Sponsor Representative Signature: ______ Date: ______

Updated 5/19/22

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member regularly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. 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 the meal reimbursement for your child care center/provider. 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.

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:

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

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT For official use only

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

Total Income

How often? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month

Household size

Categorial Eligibility ☐

Eligibility ☐ Free ☐ Reduced ☐ Denied

Determining Official's Signature | Date | Confirming Official's Signature | Date | Follow-up Official's Signature | Date

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

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.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) 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 no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"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, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Address

City

State

Zip

Phone/Email