



## Enrollment Packet

Thanks for your interest in Growing Kids Learning Centers. The Enrollment Process is as easy as...

- 1) Complete the Enrollment forms  
Bring them with you when you tour or before your child's first day.
  
- 2) Call or Meet with the Center Director to coordinate an enrollment opening and schedule a start date.  
Availability is limited and changes frequently. Children are enrolled on an as-available basis.

This Packet Includes the following forms to complete:

- o Tuition Agreement
- o Enrollment Form
- o Authorized Pick Up List & Emergency Contacts
- o Parent Questionnaire
- o Verification of Age and Consent to Report
- o Health Record (must be completed within 30 days of enrollment)
- o USDA/CACFP Food Program (for all families)

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Preferred Start Date: \_\_\_\_\_

Thank you for choosing Growing Kids Learning Center.



# Tuition Agreement

<b>Programs Available</b> (Please circle one. Ask the Director if more options are needed.)			
Infant Care (6 weeks – Walking)	5 Full Days (7:00 am - 6:00 pm)		
Toddler Care (Walking - 24 Months)	5 Full Days		
Young Preschool (24mo. - 3 years)	5 Full Days	5 Half Days	3 Full Days
Preschool (3 yrs & Potty Trained - 5 years)	5 Full Days	5 Half Days	3 Full Days
Kindergarten (5 yrs. by September 1)	5 Full Days	5 Half Days	
After School Care (Elem. Grades)	5 Days	Additional charges apply for extra ½ and full days.	
Evening Care (2 yrs and older)	Care available until 11:30 p.m. weekly or as needed. <b>Prior sign-up required.</b>		

For the Program Selected,  
Your Weekly Tuition Rate Is:

\$\_\_\_\_\_ If Paid In FULL on  
Monday **with AutoPay**  
**Discount**

\$\_\_\_\_\_ Regular Tuition Rate  
(no AutoPay Discount)

This amount can change if  
your child's program changes.

### Payments and Due Dates

All Payments are due in advance weekly on Mon. morning.  
Advanced payments are accepted.  
All payments are non-refundable.  
The annual registration fee of \$50 is charged upon enrollment and every August thereafter.  
A Service fee of \$25 is charged for all returned payments.  
Non-Payment of Tuition can terminate enrollment.  
Forms of payment accepted: Debit Cards, Checks, Visa / MasterCard, ACH from Bank Account (checking or savings).

**Parent(s) signing below are responsible for paying any balance due, including any balances remaining after payments from childcare voucher, 3<sup>rd</sup> party reimbursement, or other outside source.**

### Late Pick Up Fees

A fee of \$5 is charged for every 15 minutes a child is picked up after the scheduled pick-up time. Payment is due immediately. See the Parent Handbook for more info.

### Holiday Schedule

The center will be closed on the following holidays (or closest weekday). The regular tuition is still due these weeks. Evening Care schedule may be adjusted as well.

- New Year's Day
- Memorial Day
- July 4<sup>th</sup>
- Labor Day
- Thanksgiving
- Christmas Day

### Schedule or Program Changes

If your child's schedule or program changes, your tuition will change accordingly. To request a schedule change, please notify the director in writing. Your tuition can change with 30 day notice.

To qualify for the AutoPay Discount, your balance must be paid in full by Monday of each week, through our AutoPay program.

Your tuition is due in full each week regardless of illness or other absence. The center does provide 2 weeks "Vacation" per calendar year where tuition is waived when your child does not attend. Vacation requests should be in writing -- Please see the Parent Handbook for details. Overdue accounts will be charged a service fee. The parent understands that he/she assumes all responsibility for interest charges, collection agency, legal or court fees associated with the collection of this account, if that becomes necessary. Parents electing to withdraw their child must provide two weeks written notice to the center. Any issue under this agreement or relating to the service provided shall be subject to mediation and, if not resolved by mediation, arbitration under the rules of the American Arbitration Association.

Child: \_\_\_\_\_

Parents' Signatures: \_\_\_\_\_

Date: \_\_\_\_\_

Director: \_\_\_\_\_



## AutoPay Registration Form

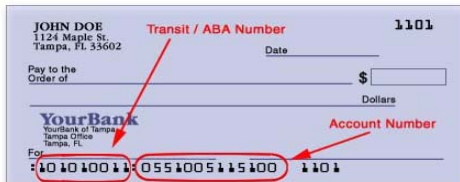
The AutoPay Tuition Discount is offered to parents who enroll in the AutoPay program. Enrolled families receive a discount on weekly tuition when their account is paid in full on Monday.

Child Name: \_\_\_\_\_ Center: \_\_\_\_\_  
 Payer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Receipt Required: yes no  
 Address: \_\_\_\_\_  
 City / State/ Zip: \_\_\_\_\_

### Checking / Savings Account Payments

I authorize Growing Kids to initiate withdrawals from my checking or savings account for recurring and incidental charges at the financial institution listed below in payment of my account. This authority will remain in effect until 5 days after I provide written notice to cancel it.

Bank Name: \_\_\_\_\_  
 Bank Address: \_\_\_\_\_  
 Transit / ABA#: \_\_\_\_\_  
 Account #: \_\_\_\_\_  
 Account Type: Checking Savings Starting Date: \_\_\_\_\_



### Debit / Credit Card Payments

I authorize Growing Kids to initiate charges to my credit or debit card listed below in payment of my account for recurring and incidental charges. This authority will remain in effect until five days after I provide written notice to cancel it.

Card Type: VISA MASTERCARD DISCOVER  
 Card #: \_\_\_\_\_ Expiration \_\_\_\_\_

### No, thank you

I prefer not to participate in the AutoPay program at this time. I understand that I will not receive the AutoPay discount from the standard tuition rate unless I choose to participate in the program.

Payer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only	
Center:	Child's Name:
Tuition:	AutoPay Start Date:



**Student Information**

Name: \_\_\_\_\_  
 Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
 Child Lives With: \_\_\_ Mother \_\_\_ Father  
 \_\_\_ Other: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

Start of Care: \_\_\_/\_\_\_/\_\_\_

Gender: \_\_\_ Boy \_\_\_ Girl

Parents are: \_\_\_ Married \_\_\_ Single

\_\_\_ Other \_\_\_\_\_

In the chart below, please indicate the normal **days and hours** your child is in care, and the **meals received** while in care.

	MON	TUE	WED	THUR	FRI
Please enter the normal hours your child is in care (e.g. 7:30 – 5:30pm)					
Please check (✓) the meals your child normally receives while in care	___ AM Snack ___ Breakfast ___ Lunch ___ Afternoon Snack ___ Dinner ___ Evening Snack	___ AM Snack ___ Breakfast ___ Lunch ___ Afternoon Snack ___ Dinner ___ Evening Snack	___ AM Snack ___ Breakfast ___ Lunch ___ Afternoon Snack ___ Dinner ___ Evening Snack	___ AM Snack ___ Breakfast ___ Lunch ___ Afternoon Snack ___ Dinner ___ Evening Snack	___ AM Snack ___ Breakfast ___ Lunch ___ Afternoon Snack ___ Dinner ___ Evening Snack

This information is required by CACFP federal regulations at §226.15(e)(2) and (3) for each enrolled child and must be updated **annually**.

- Check if your child's schedule may vary
- Check if your school aged child might attend before/after school care and school holidays during the school year.

**Parent (Guardian) Information**

	<b>First Parent</b>	<b>Second Parent</b>
Relationship	___ Mother ___ Father	___ Mother ___ Father
Name:	_____	_____
Home Address:	_____	_____
City/State/Zip Code:	_____	_____
Home Phone:	_____	_____
Email Address:	_____	_____
Cell Phone:	_____	_____
Cell Phone Carrier:	_____	_____
Employer Name:	_____	_____
Employer Phone:	_____	_____
Employer Address:	_____	_____
Work Hours:	_____	_____
Soc. Sec. Last 4 Digits:	XXX-XX-_____	XXX-XX-_____



**Authorization and Consent**

I/We state that we are the legal parent/guardian of the minor child listed below.

Please Initial

\_\_\_\_\_ **Authorization for Medical Treatment of a Minor** – I authorize, for emergency purposes only, Growing Kids Learning Center to transport my minor child and to consent to any necessary examination, medical diagnosis, surgery or treatment, and / or hospital care to be rendered to the minor child listed below, under the general or special supervision and on the advice of any physician licensed to practice in the state of Indiana.

\_\_\_\_\_ **Liability Release for Services Provided Outside of Growing Kids Learning Center** – I release and hold harmless Growing Kids Learning Center, its owners, and its employees from any liability or accident that may occur should I retain the services of any Growing Kids employee for services **outside** the learning center. I also agree not to solicit Growing Kids employees away from the learning center for alternate employment opportunities.

\_\_\_\_\_ **Photo Release** – Growing Kids, its affiliates and agents, may use photographs, video recordings, reproductions, images, and sound recordings of my child for advertising, publicity, or other lawful use.

\_\_\_\_\_ **Authorized Pick Up** - Children will be released only to a parent or a person named by the parent. Parents or persons named by the parent must make sure that a staff member is aware of the child’s arrival and departure. Parents shall sign the child in and out by name and time of arrival and departure. Parents cannot share access codes, computer passwords, and other security measures with unauthorized people.

\_\_\_\_\_ **Receipt of Growing Kids Parent Handbook** – I have read and understand the Growing Kids Parent Handbook that was given to me upon enrollment.

\_\_\_\_\_ **Agreement to Pay Tuition** – I have read and signed a Tuition Agreement form that specifies the tuition amount and the frequency of payments to Growing Kids for services rendered.

Name of Child: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Thank You for Choosing Growing Kids Learning Center**

We are dedicated to providing the highest quality child care. Please feel free to speak with your child’s teacher or the center director regarding any question or concern you may have. We welcome your comments and involvement in the center.

Office Use Only –	Center:
Enrollment Offer Date:	Expected Start Date:
Enrollment Offered by:	Offer Expiration Date:
Classroom / Schedule:	



# Authorized Pick Up List & Emergency Contact List

This form designates what adults are able to drop off and pick-up your child from the Growing Kids Learning Center and what adults to contact in the event of an emergency. Please list the adults in the order you would like us to contact them in the event of an emergency or, more likely, a student illness.

Student Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Contact  
Order

	Name	Address	Relation	Phone Number	Pick Up Only
1	Mother or Father			Home: _____ Work: _____ Cell: _____ Other: _____	<input type="checkbox"/>
2	Mother or Father			Home: _____ Work: _____ Cell: _____ Other: _____	<input type="checkbox"/>
3				Home: _____ Work: _____ Cell: _____ Other: _____	<input type="checkbox"/>
4				Home: _____ Work: _____ Cell: _____ Other: _____	<input type="checkbox"/>
5				Home: _____ Work: _____ Cell: _____ Other: _____	<input type="checkbox"/>
6				Home: _____ Work: _____ Cell: _____ Other: _____	<input type="checkbox"/>

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Allergies or Other Restrictions: \_\_\_\_\_

Pick Up Restrictions (legal documentation generally required): \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**A copy of this form to accompany the child on all field trips.**



Life  Cubby.me

your child's digital content all in one place  
serving early childhood programs and parents worldwide



Date: \_\_\_\_\_

Dear Parents,

We have very exciting news! Our school is using an online communication tool to replace the paper messenger notes home, called "LifeCubby." With LifeCubby, you will be able to access your account both online and with an app. LifeCubby allows our school to go paperless with daily reports, activity documentation (including photos/videos) and assessments. You can get the FREE [LifeCubby Family App](#) in both Google Play and iTunes.

We will create your child's cubby, and you will receive an e-vite with your login and password. Please check your email. Your username and password are generated by the system at first, but then once you login you can change them.

Our teachers will use LifeCubby to provide you with journaling about your child's day and daily activities. You, as parents, will also be able to use LifeCubby for your own documentation, as well. You can also invite friends and relatives to be "Cubby Pals" and share the memories. Use the LifeCubby website to manage your account settings and invite "Cubby Pals." Use the LifeCubby Family App to view school uploads and add your own content.

You will have the ability to see your child's Daily Sheet in "Real Time" with updates throughout the day. However, please keep in mind that sometimes the teachers will post updates when they have time, as they are so busy with the children :) So, please don't worry if you check your child's Daily Sheet and see that nothing has been posted yet. The teachers generally post documentation when they have time which might be later in the day.

For more information, please visit [www.lifecubby.me](http://www.lifecubby.me) or talk to the center director.

Please read and sign the "Photo / Video Share Statement of Understanding" on the next page. Signed forms can be turned in at the front desk.

Please don't hesitate to let us know if you have any questions as we transition to a more paperless school.

Thank you!



## Understanding of the Use of Technology in a Group Care Setting, Including:

- Photos & Videos
- Documentation of Daily Activities and Care Events
- Documentation that is Sensitive or Confidential
- Use of Visible Classroom Computer Screens (Documentation Stations) for the Staff

I understand that my child is enrolled in a group care setting. Teachers and caregivers are responsible for the documentation of the day and communications for the benefit of everyone (parents, children, administration, and oversight agencies). I accept and approve of the following:

### **Photos & Videos**

Teachers will be taking both photos and videos in the classroom. I will have access to the entries that include my child. Some entries might be individualized documentation about only my child. Other entries might be about group activities that include multiple children. I will contact the school if there is a photo or video that I want removed. If I want only digital daily sheets but no photos or videos, I will let the center know. I will abide by the school's policy of **no re-posting or forwarding** photos or videos to other digital platforms.

### **Documentation of Daily Activities and Care Events**

Teachers will use center-provided computers, tablets, or iPods to post photos, videos and daily care events, such as daily activities meals, diaper changes and naps. The amount recorded daily will look different based on the child's age. The security on these devices only allow LifeCubby access – Nothing else online is permitted. My daily reports will be digital, accessible by me via my account in an app and online. I understand that when I see teachers interacting with computers, tablets or iPods in the classroom, they are performing the required duty of documentation.

### **Documentation that is Sensitive or Confidential**

Some of the documentation that teachers are required to maintain may be sensitive or confidential, such as medications administered or disciplinary action. I understand that teachers will need to use classroom technology for this documentation, and I will always respect the privacy of the classroom technology.

### **Use of Visible Classroom Computer Screens (Documentation Stations) for the Staff**

Live messaging, similar to Intercom Systems, are incorporated as a part of the LifeCubby system. An example of a live message might be an alert that will appear on the screen to remind the teachers that it is time to administer medication for a student. I understand the confidential nature of such an alert message, and will not violate the privacy rights of that child and parents. I understand and agree to the following: If what is on the screen does not pertain to me or my child, it is none of my business and I will ignore it. To keep the focus on the class our teachers will not be responding to live messaging from parents throughout the day. You may call the office if you need to be in touch with them.

By signing the permission slip, I understand and agree to the terms listed above and the use of LifeCubby for my child at my child's school.

Child's Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date





Child Information

Child's Full Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_
Name Child is Called \_\_\_\_\_ (circle gender) Male Female

Please Fill Out the Following Information

List all persons living in the household

Table with 3 columns: Name, Relationship to child, Age. Includes three rows of blank lines for data entry.

Describe child's previous child care experience
\_\_\_\_\_
\_\_\_\_\_

Developmental History

Type of Birth Normal Premature Complications \_\_\_\_\_

Languages spoken in the home \_\_\_\_\_ Primary Language \_\_\_\_\_

Any difficulties in speaking? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Circle if child can:

- Crawl Walk (more than 5 steps on own) Put on shoe Button
Tie shoe Buckle Zip zipper Dress self Feed self

Explain any difficulties in physical development \_\_\_\_\_

Toilet Training (circle)

- Child is in a Diaper Pull-up Training Pant Underwear
Child is successful on the toilet Always Urine BM
Child stays dry All Day Through Nap Through Night
Child will go to toilet By Self When Asked

Sleep Habits

When is child's bedtime? \_\_\_\_\_ When does he awaken? \_\_\_\_\_ Does he/she share a room? \_\_\_\_\_
With whom? \_\_\_\_\_ Own bed? \_\_\_\_\_ Shared with whom? \_\_\_\_\_
What is child's general mood upon awakening? \_\_\_\_\_
Nap Schedule \_\_\_\_\_



**Eating Habits**

Favorite foods \_\_\_\_\_

Foods disliked \_\_\_\_\_

List any foods child can not eat (Must have a Doctor's note) \_\_\_\_\_

Is child on (circle)      Breast Milk      Formula      2% milk      Other \_\_\_\_\_

Does child drink from a bottle? \_\_\_\_\_ Use a sippie cup? \_\_\_\_\_ Open cup? \_\_\_\_\_

Eat table food? \_\_\_\_\_ Use a pacifier? \_\_\_\_\_ Suck Thumb? \_\_\_\_\_

\* **Parents of infants must complete the enclosed *Feeding Plan* and have it signed by child's doctor.**

**Social and Emotional Behavior/Experience**

Does child have temper tantrums? \_\_\_\_\_ Explain \_\_\_\_\_

Does child pick up toys after playing? \_\_\_\_\_

With what age group does child usually play? \_\_\_\_\_ Favorite Toy? \_\_\_\_\_

How does child relate to new people? \_\_\_\_\_

What upsets your child? \_\_\_\_\_

What makes child happy? \_\_\_\_\_

How does child demonstrate anger? \_\_\_\_\_

How do you discipline at home? \_\_\_\_\_

How best would you describe your child's disposition? \_\_\_\_\_

Child is frightened by (circle)

Animals      Loud noises      Sirens      Darkness      Water      Other \_\_\_\_\_

Concerns or Comments?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent Signature

Date

Parent Signature

Date



# Verification of Age and Consent to Report

Pursuant to Indiana law, Growing Kids must verify each child's birth date. As part of that law, we must also report the names of the children that enroll or withdraw from the center.

**1. Proof of Age** – Required of all children.

Please present to the Growing Kids office a documented copy of your child's birth certificate or any other documentable record. We only have to see it and make a copy. We will not keep the original.

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**2. Consent -** Please choose whether or not to provide permission for the center to include your child's name in the enrollment report to the Division of Family and Children. While the center is required by law to submit the report, participation is voluntary for parents.

***Please Choose One***

**Yes, I give my permission** for Growing Kids to report the name and birth date of my child to the Division of Family and Children, pursuant to IC 12-17.2-2-1.5

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**No, I do not give my permission** for Growing Kids to report the name and birth date of my child to the Division of Family and Children, pursuant to IC 12-17.2-2-1.5

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

**For Office Use Only** -----

Proof of Birth Date Provided:                      Yes                      No

Copy Put in Child's File                              Yes                      No

Completed by: \_\_\_\_\_  
Staff Member / Date



# Child Care Center Health Record

Child's Name (last, first)		Date of Birth	Admission Date
Address			
Child lives with (relationship)	Name		Telephone Number

Medical History		
Communicable Disease	Month / Year	Condition / Explain if Present
Measles		Allergies:
Rubella (German Measles)		
Chicken Pox		Handicapping Conditions:
Mumps		
Scarlet Fever		Other:
Whooping Cough		
Hepatitis B		
Other: _____		

Physical Examination	
Date of Exam:	Age of child:
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:
Note any unusual findings:	
<p>Does this child have any health condition that would be hazardous to the child or to other children in a group setting as a result of participation in normal activities (including sports)? If yes, what modifications of normal activities would be necessary to protect the child and the child's classmates?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	
<p>Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> NO</p>	

(Over)



**History of Immunizations and Tests** (*indicate month/day/year*)

	1	2	3	4	5
DTP/DT/Td					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV					

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

	1	2	3	4
Pneumococcal (PCV)				

	1	2	3
HBV			

Note: To be considered adequately immunized, a child of age 24 months should have received four DTP inoculations, three polio inoculations, one inoculation against measles, mumps, and rubella, and at least 3 Hib vaccinations.

Name of physician completing form (please print)	Telephone Number
Signature of physician	

<b>Additional Notes and Instructions</b>
<hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/> <hr style="border-top: 1px dashed black;"/>



# Help Us Provide Better Meals and Snacks!

We need EVERY FAMILY to complete the attached form  
and return it to the office NOW!\*

It only takes a few minutes.

To provide higher quality meals and snacks for the children at the center, this center participates in the US Department of Agriculture's CACFP food program.

For every family enrolled, the center receives some reimbursement from the food program. The center receives *higher* reimbursement when more families properly complete this form.

The funds the center receives from the food program enable us to provide higher quality meals and snacks to the kids at no additional cost to the parents. It is basically an extra source of funds (besides parent tuition).

If you have any questions, please ask. We would be happy to help.

Thanks

\*Why NOW? Because if you take it home, it probably won't come back for awhile...  
We understand. Life gets pretty busy.



Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Growing Kids- Ireland Rd** 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 Application for Free and Reduced Price Meals. 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. **Return the completed form to: Growing Kids 17850 Ireland Rd South Bend, IN 46614**
- 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 the 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 **Jessica White, 17850 Ireland Rd South Bend, IN 46614, 574-299-4979**
- 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.

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 **574-299-4979**

Sincerely,  
**Jessica White**

## CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

<b>SPONSOR NAME: GK SOUTH CHILDCARE CORP</b>	<b>PHONE NUMBER: (574) 299-4979</b>
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<b>CENTER: IRELAND RD</b>	<b>FDC PROVIDER:</b>
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<b><u>PART 1. ALL HOUSEHOLD MEMBERS</u></b>	BIRTH DATES OF CHILDREN	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 4 TO SIGN THIS FORM.	CHECK IF NO INCOME
NAMES OF ALL HOUSEHOLD (FIRST, MIDDLE INITIAL, LAST)			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**PART 2. BENEFITS:** IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVED [FOOD STAMPS] OR [STATE 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.** IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY CHECK THE APPROPRIATE BOX AND CALL IRELAND RD AT (574)299-4979

HOMELESS       MIGRANT       RUNAWAY

**PART 4. TOTAL HOUSEHOLD GROSS INCOME—**YOU MUST TELL US HOW MUCH AND HOW OFTEN **CHECK IF NO INCOME**

A. NAME (LIST ONLY HOUSEHOLD MEMBERS WITH INCOME)	B. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED			
(EXAMPLE) JANE SMITH	1. EARNINGS FROM WORK BEFORE DEDUCTIONS	2. WELFARE, CHILD SUPPORT, ALIMONY	3. PENSIONS, RETIREMENT, SOCIAL SECURITY, SSI, VA BENEFITS	4. ALL OTHER INCOME
	\$200/WEEKLY _____	\$150/TWICE A MONTH _____	\$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 4 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: XXX - XX - \_\_\_\_\_  I DO NOT HAVE A SOCIAL SECURITY NUMBER

\_\_\_\_\_ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

**PART 6: Other Benefits:** THE LAS ALLOWS US TO TELL MEDICAID AND HOOSIER HEALTHWISE THAT YOUR CHILDREN ARE ELIGIBLE FOR FREE OR REDUCED PRICE MEALS. WE MAY SHARE YOUR APPLICATION INFORMATION WITH MEDICAID OR HOOSIER HEALTHWISE UNLESS YOU DO NOT WANT US TO. IF YOU DO NOT WANT US TO SHARE THIS INFORMATION, PLEASE SIGN HERE:

\_\_\_\_\_ FOR INFORMATION ABOUT HOOSIER HEALTHWISE HEALTH INSURANCE

CALL 1-800-889-9949

SIGNATURE OF PARENT OR GUARDIAN



# CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

A CHILD ENROLLED IN THE DAY CARE FACILITY MAY QUALIFY FOR FREE OR REDUCED PRICE MEALS IF THE HOUSEHOLD INCOME FALLS AT OR BELOW THE LIMITS ON THIS CHART:

JULY 1, 2018 TO JUNE 30, 2019			
HOUSEHOLD SIZE	MONTHLY INCOME	HOUSEHOLD SIZE	MONTHLY INCOME
1	1,872	5	4,536
2	2,538	6	5,202
3	3,204	7	5,868
4	3,870	8	6,534

FOR EACH ADDITIONAL FAMILY MEMBER, ADD **\$666**

## PART 7. PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

MARK ONE ETHNIC IDENTITY: <input type="checkbox"/> HISPANIC OR LATINO  <input type="checkbox"/> NOT HISPANIC OR LATINO	MARK ONE OR MORE RACIAL IDENTITIES: <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN
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**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.

*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, audiotope, 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](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](mailto:program.intake@usda.gov).

*This institution is an equal opportunity provider.*

## CHILD CARE REPRESENTATIVE USE ONLY

ANNUAL INCOME CONVERSION: WEEKLY X 52 – EVERY 2 WEEKS X 26 – TWICE A MONTH X 24 – MONTHLY X 12

<p><b>SECTION A</b> MARK ONE OF THE BOXES BELOW TO SHOW HOW YOU ARE GOING TO DETERMINE ELIGIBILITY.</p> <p><input type="checkbox"/> <b>FOOD STAMP OR TANF HOUSEHOLD</b>—THE FOOD STAMP OR TANF NUMBER MEETS THE CRITERIA FOR AN ACCEPTABLE CASE NUMBER. COMPLETE SECTION B &amp; C                                      <b>OR</b></p> <p><input type="checkbox"/> <b>FOSTER CHILD</b>—COMPARE THE FOSTER CHILD'S PERSONAL INCOME TO THE GUIDELINES. COMPLETE SECTION B &amp; C                                      <b>OR</b></p> <p><input type="checkbox"/> <b>HOUSEHOLD INCOME</b>—COMPLETE THE INFORMATION BELOW AND COMPLETE SECTION B &amp; C                  TOTAL HOUSEHOLD SIZE: _____                  TOTAL HOUSEHOLD INCOME                  \$ _____ / _____                  EXAMPLE: \$100/WEEK</p> <p>COMPARE TOTAL HOUSEHOLD INCOME TO CURRENT USDA INCOME ELIGIBILITY GUIDELINES. WHEN THE HOUSEHOLD INCOMES ARE LISTED FOR DIFFERENT PAY PERIODS, YOU MUST CONVERT ALL INCOME TO MONTHLY OR ANNUAL INCOME. USE THE CONVERSION LISTED ABOVE.</p>	<p><b>SECTION B</b>                  BASED ON THE INFORMATION PROVIDED, THIS APPLICATION WILL BE:  <input type="checkbox"/> APPROVED FREE                                      <input type="checkbox"/> APPROVED TIER I  <input type="checkbox"/> APPROVED REDUCED                                      <input type="checkbox"/> APPROVED TIER II  <input type="checkbox"/> PAID</p> <p>USE THIS SPACE FOR INCOME CALCULATION.</p> <hr/> <p><b>SECTION C</b></p> <p style="text-align: center;">_____ SIGNATURE OF SPONSOR REPRESENTATIVE</p> <p style="text-align: center;">_____ DATE OF APPROVAL</p> <p style="text-align: center;"><b>THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED</b></p>
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