

A watercolor-style illustration of a large, leafy green tree with a thick brown trunk. At the base of the tree, six diverse children are holding hands and playing in a grassy field. The children are wearing colorful clothing: a white shirt and blue pants, a red and white striped shirt, a green and white patterned shirt, a yellow shirt and blue pants, a pink and purple patterned shirt, and a blue and white checkered dress. The background is a light blue sky with a few falling leaves.

Third Presbyterian Church
Preschool & Youth Center

“Growing God’s Garden”

9990 Lewis & Clark Blvd
St. Louis, MO 63136
314-868-9600

**ENROLLMENT PACKAGE
2018-2019**

Enrollment Checklist

(For Office Use Only)

- Completed & Signed Enrollment Application
- Signed Program Policies(Signed Transportation & Media Authorization/Late Pick Up)
- Release of Participation Form
- Authorization For Emergency Medical Care
- Child's Health Statement
- Immunization Records
- Submitted Physical Exam
- Meal Substitution Form
- CACFP Enrollment Form
- Income Eligibility Form
- Submitted Deposit

Notes:

THIRD PRESBYTERIAN CHURCH
 PRESCHOOL & YOUTH PROGRAM
PARTICIPANT ENROLLMENT FORM

CHILD'S NAME	SEX	AGE	BIRTHDATE	T-SHIRT SIZE
ADDRESS	CITY		STATE	ZIP CODE
SCHOOL ATTENDING & GRADE (SCHOOL-AGERS ONLY):				

PARENT/GUARDIAN CONTACT INFORMATION

MOTHER / GUARDIAN NAME			HOME PHONE ()
ADDRESS (__ CHECK HERE IF SAME AS THE CHILD)			CELL PHONE ()
EMPLOYED BY / SCHOOL ATTENDING			E-MAIL ADDRESS
ADDRESS (INCLUDE CITY, STATE, ZIP CODE)			BUSINESS PHONE NUMBER ()
FATHER / GUARDIAN NAME			HOME PHONE ()
ADDRESS	CITY	ZIP	CELL PHONE ()
EMPLOYED BY / SCHOOL ATTENDING			BUSINESS PHONE NUMBER ()
ADDRESS (INCLUDE CITY, STATE, ZIP CODE)			E-MAIL ADDRESS

EMERGENCY CONTACTS (TWO REQUIRED)

NAME	HOME PHONE	CELL PHONE
ADDRESS (INCLUDE CITY, STATE, ZIP CODE)		RELATIONSHIP
Contact is authorized to pick child up?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
NAME	HOME PHONE	CELL PHONE
ADDRESS (INCLUDE CITY, STATE, ZIP CODE)		RELATIONSHIP
Contact is authorized to pick child up?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

COMMENT ON PARTICIPANT'S DEVELOPMENT

(NOTE ALLERGIES, HABITS, SPECIAL LANGUAGE, BEHAVIOR PATTERNS, ETC.)

TO BE COMPLETED BY PROGRAM STAFF (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)

START DATE	ENROLLED (DAYS OF THE WEEK & TIMES)	FAMILY SUPPORT DIVISION <input type="radio"/> YES <input type="radio"/> NO CASE WORKER NAME _____ CASE WORKER NUMBER _____
FILE COMPLETED BY	TITLE	
DISCHARGE DATE	STAFF SIGNATURE	

TRANSPORTATION & MEDIA AUTHORIZATION

I, the parent/guardian of the registrant, a minor, agree that the registrant and I will abide by the rules of TPC. Recognizing the possibility of physical injury associated with the activities and in consideration for TPC accepting the registrant for its programs and activities, I hereby release, discharge, hold harmless, absolve and / or otherwise indemnify TPC, the employees and associated personnel, its affiliated organizations, vendors and sponsors, including the owners of fields and facilities utilized for the Programs, and all others who have participated in the planning, organizing and implementing of the activities, against any claim and from responsibility, loss, cost, damage and liability for or by reason of any illness, injury, death, misadventure, harm, loss or inconvenience suffered or sustained by or on behalf of the registrant as a result of the registrant's participation in the program and/or being transported to or from the same, which transportation I hereby authorize.

I, agree that TPC may use any photographs taken of my child for promotional activities. TPC may also use any works created by my child for promotional activities. This includes drawings, crafts, or written words.

Parent/Guardian: _____
PRINT

Signature _____

Date ____/____/____

Late Pick Up Policy:

1. Parents are notified of expected drop-off and pick-up times for their child at the time of enrollment.
2. Parents who fail to pick up the child at the agreed upon time create a hardship for employees and the Afterschool Program incurs additional costs for providing child care services.
3. If a parent fails to abide by the agreed upon pick-up and drop-off time, the parent will be assessed a late pick-up fee for each day a child remains at the center beyond the agreed upon time. This policy applies to all enrollees.
4. Late fees will be assessed on the following basis:
 - a. At the discretion of the Program Administrator, parents will be given a maximum of 2 late days during the course of the year (from the child's enrollment date) without a fee assessment to allow for unexpected emergencies. On these days, parents are expected to notify the center of their anticipated late arrival to retrieve their child.
 - b. 1 to 5 minutes.....\$10.00 per child
 - c. 6 to 15 minutes.....\$15.00 per child
 - d. 16 to 30 minutes.....\$30.00 per child
 - e. Over 30 minutes.....\$1.00 per minute

*The Division of Family Service and/or the Moline Acres Police Department will be notified if any child is not picked up by 7:00 p.m. Excessive late arrivals may result in termination from the program.

Any fees for late pick-up are due by CHECK or MONEY ORDER at the time the child is picked up or at the time the child returns to the center for services.

I have read and agree to the terms and conditions of this policy.

Parent Signature _____ Date _____

RELEASE FORM

The following people are permitted to pick up my child, _____ from Third Presbyterian Church's Youth Program (Do not include parents below):

Name:	Relationship
Home #:	Cell #:

Name:	Relationship
Home #:	Cell #:

Name:	Relationship
Home #:	Cell #:

Name:	Relationship
Home #:	Cell #:

Mother's Name

Contact Number(s)

Father's Name

Contact Number(s)

PARTICIPANT'S LAST NAME

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize

THIRD PRESBYTERIAN CHURCH PRESCHOOL & YOUTH CENTER

to contact the following:

PHYSICIAN OR CLINIC

(Please list name and phone number of physician and / or clinic.)

NAME

TELEPHONE

()

ADDRESS

CITY

STATE

ZIP CODE

IN CASE OF EXTREME EMERGENCY, PARTICIPANT WILL BE TAKEN TO THE NEAREST HOSPITAL.

PREFERRED HOSPITAL

(Please list name and phone number of hospital.)

NAME

TELEPHONE

()

ADDRESS

CITY

STATE

ZIP CODE

SPECIAL NEEDS

Please check all that apply:

- | | | |
|-------------------------------------|------------------------------|---------------------------------------|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> LD | <input type="checkbox"/> AUTISM |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> BD | <input type="checkbox"/> ED |
| <input type="checkbox"/> BIPOLAR | <input type="checkbox"/> ODD | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> MR / DD | | _____ |

Does the participant have an IEP? ____ Yes ____ No

Is the participant a foster child? ____ Yes ____ No

Additional Information: _____

TRANSPORTATION AUTHORIZATION

I ____ DO ____ DO NOT Give permission for the facility to transport my child to and from the site.

ACKNOWLEDGEMENTS

- A) I have received a copy of this facility's policies pertaining to the admission, care, and discharge of children.
- B) I have been informed that a copy of the licensing rules for group child care homes and child care centers is available at this facility for review.
- C) The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior and individual needs.
- D) When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.

PARENT / GUARDIAN SIGNATURE

DATE



IDENTIFYING INFORMATION

CHILD'S NAME

BIRTH DATE

HEALTH STATEMENT (CHECK ONE)

My child is in good health, is able to participate in group care, and has no special health or medical requirements.

My child is able to participate in group care but has special health or medical requirements as listed below.

SPECIAL HEALTH OR MEDICAL REQUIREMENTS.

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

Please indicate the best action for items listed above:

PLEASE ATTACH A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORDS.

In accordance with Section 210.003.7, RSMo., the parent or guardian of a child enrolled in Third Presbyterian Church Preschool & Youth Center may request notice of whether there are any children enrolled at our facility with an immunization exemption on file. If you would like to request this information, please contact the Director and the information will be provided to you. Please, note the name or names of individual children are confidential and will not be released. Our response will be limited to whether or not there are children enrolled at our facility with an immunization exemption on file.

Parent or Legal Guardian Signature

Date

THIRD PRESBYTERIAN CHURCH
 PRESCHOOL & YOUTH PROGRAM
 MEDICAL FOOD SUBSTITUTION RECORD

Authorization by a recognized medical authority is required for food substitutions for food service in At-risk youth centers. A recognized medical authority includes a physician assistant, or nurse practitioner. The recognized medical authority must specify, in writing, the food to be omitted from the patient's diet and the food or choice of foods that may be substituted.

PATIENT'S NAME

MEDICAL DIAGNOSIS / REASON

SPECIAL ASSISTANCE / EQUIPMENT REQUIRED

FOOD SUBSTITUTION LIST

FLUID MILK	ALLOWED SUBSTITUTIONS	TEXTURE (e.g. CUT UP, GROUND MINCE, PUREE, LIQUIDITY)
MEAT & MEAT ALTERNATIVE (e.g. EGGS, CHEESE, PEANUT BUTTER, BEANS, YOGURT)	ALLOWED SUBSTITUTIONS	TEXTURE
BREAD, CEREAL OR WHOLE GRAIN PRODUCTS	ALLOWED SUBSTITUTIONS	TEXTURE
FRUIT & VEGETABLE OR JUICE	ALLOWED SUBSTITUTIONS	TEXTURE

Additional dietary concerns and/or required equipment or assistance needed:

I (medical authority) certify that the above patient must be provided a special diet or requires special accommodations as indicated above.

Signature

Title

Date

Child's Name: _____

WEEKLY PROGRAM FEES		
	FULL TIME	PART TIME
PRE-SCHOOL*	\$120	N/A
SCHOOL AGE – EXTENDED CARE PROGRAM	\$65	\$35 (Before Care only) \$45 (After Care only)

*Add a \$10/week potty-training fee to tuition or sliding fee for any child not potty trained.

ANNUAL BOOK FEE	
2 Yr olds	\$25/yr
3-4 Yr olds	\$35/yr
Pre-K	\$45/yr

Please initial by each statement below to indicate that you have read and agree to the policy as stated:

- There is a non-refundable annual registration fee of \$50/student. If your child receives state assistance, then the registration fee is \$20.
- There is an annual book fee that is due at enrollment. (See above for pricing.) No book will be issued to the child until the book fee is paid in full. In addition, a \$5/day late fee will be applied for book fees not paid in full within 2 weeks after enrollment.
- A one-week non-refundable tuition deposit must be paid at enrollment. This deposit can be applied to your child's final week of attendance provided that you notify the Director, in writing, two weeks in advance of withdrawal from the program. If two weeks advance notice of withdrawal is not given to the Director the deposit is forfeited.
- ***Program fees (tuition, fees, etc.) are due on Thursday, prior to the week of service with a grace period extending until close of business on Friday. If program fees are not paid by close of business on Friday, a late fee of \$10.00 the first day (Monday 5:59 a.m.) and \$5.00 each additional day payment is not received will be assessed. Failure to pay the late fees will result in the continued accrual of the late fees until paid in full or may result in the discontinuation of services.***
- There is a \$10/week Potty Training Fee for any student not fully potty-trained. A student is considered fully potty-trained children when they can communicate the need to use the restroom without prompting from an adult AND has fewer than 1 accident per week AND is consistent for at least 30 days.
- It is imperative that you accurately complete your child's Sign In/Out sheet each day. Failing to do so may result in the State rejecting our invoice for your child (State Assistance Only) or the CACFP rejecting our invoice for our food program. In this case, the parent is responsible for the full tuition or any monies lost as a result of their negligence.
- State Assistance Only: If you desire for your child to begin receiving services prior to our receipt of the Child Care Provider Approval/Change Notice from the MO Department of Social Services, you will be charged the regular weekly tuition rate. Upon receipt of the Child Care Provider Approval/Change Notice a refund of the difference between the regular weekly tuition and the state approved sliding fee (provided that the approval authorization is dated back to the date services began) will be issued for the current month only.
- To maintain our high standard of quality, we budget for everyday costs related to our dedicated teachers and education resources. Therefore, to cover these costs, we charge a full-week of tuition/sliding fee if your child attends any portion of the week.
- If a child is ill and out of school for an entire week or more, a discounted rate may be approved, but is not guaranteed, by the Director. A doctor's statement must be submitted before a discount, if any, will be considered.
- In the event that a child contracts a major illness or suffers a major injury that will require an absence in excess of two weeks, arrangements must be made with the Business Administrator for a tuition waiver. A physician's statement must be submitted indicating that the child is prohibited from attending school. There is no waiver of tuition for illnesses/injuries under two weeks.
- There is no tuition waiver or reimbursements given for family vacations, absences or holidays. Full tuition or sliding fees are due regardless of the child's attendance and late fees will be applied for payments made past the due date. A child who is absent for 14 consecutive days will be considered disenrolled and their deposit will be forfeited.
- Any changes or adjustments concerning your tuition agreement must be made at least 1 week in advance and acknowledged in writing by the Business Administrator or Director. No more than three (3) payment agreements will be granted per school year. If your account falls behind with no prior arrangements, we will not be able to continue serving your child and your account may be turned over to a collection agency.
- All outstanding balances must be paid prior to a child attending a field trip. Field trip fees will not be accepted on the day of the field trip.
- A \$15 laundry and usage fee will be assessed for not providing fresh clean bedding on Monday by 11 a.m. or the first day of the week that the child attends school or after bedding has been soiled by the child. Laundry fees must be paid within 7 days of the issuance of the Laundry Fee Notification. Failure to pay within the 7 days will result in a \$5/day late fee.
- Checks or money orders are acceptable forms of payment. However, after two returned checks per year, only money orders will be accepted. A \$25 returned check fee will be added to the amount due. The returned check and fee must be submitted within 7 days of notification or the child will not be allowed to return to the program.

I have received and read the program fee agreement and agree to conform to the policies established. I understand that failure to comply with the payment policy will result in the immediate termination of services provided by Third Presbyterian Church.

Parent Signature: _____ Date _____

Religious Organization Child Care Facility Notice of Parental Responsibility

Facility Name Third Presbyterian Church reschool

Address (Street, City, State, Zip Code) 9990 Lewis & Clark, St. Louis, MO 63136

INSPECTIONS

Section 210.211 RSMo exempts this religious organization child care facility from state licensing and supervision by the Department of Health and Senior Services (DHSS). It is state inspected only for fire, health and sanitation requirements as indicated below. Copies of the inspections are available.

NAME OF AGENCY AND TYPE OF VISIT	ADDRESS	TELEPHONE NUMBER	INSPECTION	DATE
Section for Child Care Regulation (Health and Safety Inspection)	220 S. Jefferson, St. Louis, MO 63103	314-877-0219	Pending <input type="checkbox"/> Approved <input checked="" type="checkbox"/> Not approved <input type="checkbox"/>	10/24/17
Fire Marshal's Office (Fire Safety Inspection)	P.O. Box 844, Jefferson City, MO 65102		Pending <input type="checkbox"/> Approved <input checked="" type="checkbox"/> Not approved <input type="checkbox"/>	8/21/17
Local Health Office or DHSS (Sanitation Inspection)	220 S. Jefferson, St. Louis, MO 63103	314-877-2680	Pending <input type="checkbox"/> Approved <input checked="" type="checkbox"/> Not approved <input type="checkbox"/>	8/30/17

STANDARD STAFF/CHILD RATIOS ESTABLISHED BY THIS FACILITY

STAFF/CHILD RATIOS FOR LICENSED CENTERS

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 staff member for every	0
2 to 4 years of age	1 staff member for every	8:1 for 2 yr olds 10:1 for 3/4 yr olds
5 years of age and older	1 staff member for every	16

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 staff member for every	4
2 years of age	1 staff member for every	8
3 and 4 years of age	1 staff member for every	10
5 years of age and older	1 staff member for every	16

Total number of children enrolled by this facility 50

BACKGROUND CHECKS: CHILD ABUSE/NEGLECT AND CRIMINAL RECORD(S)

Statute 210.254 RSMo requires the facility to conduct background checks for child abuse/neglect and criminal record reviews on each individual caregiver and all other personnel (who have contact with children in care) at the facility at the time of employment and every two years thereafter.

Background checks for child abuse and neglect through the Children's Division (CD) and criminal record reviews through the Missouri State Highway Patrol have been conducted on each individual caregiver and all other personnel at the facility as required: Yes No

FACILITY DISCIPLINE AND EDUCATIONAL PHILOSOPHY/POLICIES

The disciplinary philosophy and policies of this facility are: To provide positive reinforcement and praise for good behavior and withholding the same for unacceptable behavior. We will use age-appropriate redirection, time-out and identification of acceptable behavior to rectify the situation. Unacceptable behavior is documented on a Behavior Modification Form and shared with the parent.

The education philosophy and policies of this facility are: To teach the whole child (spiritual, emotional, mental, physical) a developmentally appropriate and kindergarten-ready curriculum that will provide them with the skills and knowledge to excel academically, socially, emotionally and physically.

REQUIRED SIGNATURES

Statute 210.254 RSMo requires the facility to furnish two copies of this document to a parent(s) upon enrollment of a child. Parents acknowledge by signature that they have read and accepted the information contained in this document. One copy of this signed document is given to the parent(s); the other copy is retained in the child's record at the facility.

PARENT(S)

Kristen Davis

PRINCIPAL OPERATING OFFICER/FACILITY DIRECTOR

DATE

7/16/18

DATE

Cedric A. Portis Sr.

INDIVIDUAL RESPONSIBLE FOR THE RELIGIOUS ORGANIZATION – PASTOR, MINISTER, PRIEST, ETC.

7/16/18

DATE

Statute 210.254 RSMo requires a new facility to file a copy of the Notice of Parental Responsibility with the Section for Child Care Regulation at least five days prior to beginning operation. Each facility must file the Notice of Parental Responsibility annually during the month of August.

**THIRD PRESBYTERIAN CHURCH
PRESCHOOL & YOUTH PROGRAM
CACFP ENROLLMENT FORM**

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

CHILD'S FULL NAME			DATE OF BIRTH		
PARENT OR GUARDIAN NAME		STREET ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE ()		
NAME OF FACILITY THIRD PRESBYTERIAN CHURCH PRESCHOOL & YOUTH CENTER			PHONE NUMBER (314) 868-9600		
CENTER CONTACT PERSON'S NAME KRISTEN DAVIS, BUSINESS MANAGER			CHILD'S FIRST DATE ATTENDING		

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD ATTENDS			WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION.
	CIRCLE AM OR PM	CIRCLE AM OR PM	
MON	AM PM	AM PM	
TUES	AM PM	AM PM	
WED	AM PM	AM PM	
THURS	AM PM	AM PM	
FRI	AM PM	AM PM	
SAT	AM PM	AM PM	
SUN	AM PM	AM PM	

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

<input type="checkbox"/> FULL DAY CARE	<input type="checkbox"/> BEFORE SCHOOL CARE	<input type="checkbox"/> EVENING CARE
<input type="checkbox"/> HALF DAY- MORNING	<input type="checkbox"/> AFTER SCHOOL CARE	<input type="checkbox"/> OVERNIGHT CARE
<input type="checkbox"/> HALF DAY- AFTERNOON	<input type="checkbox"/> BEFORE & AFTER SCHOOL CARE	

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

<input type="checkbox"/> BREAKFAST	<input type="checkbox"/> LUNCH	<input type="checkbox"/> SUPPER
<input type="checkbox"/> MORNING SNACK	<input type="checkbox"/> AFTERNOON SNACK	<input type="checkbox"/> EVENING SNACK

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

<input type="checkbox"/> NEW YEARS DAY (JANUARY 1)	<input type="checkbox"/> INDEPENDENCE DAY (JULY 4)
<input type="checkbox"/> MARTIN LUTHER KING'S BIRTHDAY (JANUARY)	<input type="checkbox"/> LABOR DAY (SEPTEMBER)
<input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY)	<input type="checkbox"/> THANKSGIVING DAY (NOVEMBER)
<input type="checkbox"/> MEMORIAL DAY (MAY)	<input type="checkbox"/> CHRISTMAS DAY (DECEMBER 25)

SIGNATURE OF PARENT / GUARDIAN		DATE	
ANNUAL UPDATES: THE ABOVE SIGNER CERTIFIES THAT THIS INFORMATION IS CORRECT. IF CHANGES OCCUR, THE CHANGES ARE INITIALED OR A NEW FORM IS COMPLETED.	FIRST UPDATE	PARENT SIGNATURE	DATE
	SECOND UPDATE	PARENT SIGNATURE	DATE

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
 CHILD AND ADULT CARE FOOD PROGRAM
INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1 CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	BIRTH DATE	FOSTER CHILD	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

PART 2 HOUSEHOLD AND INCOME INFORMATION

List all members of the household including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE)	YEARLY	MONTHLY	2 X A MONTH	EVERY 2 WEEKS	WEEKLY
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER	

PART 3 RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? YES NO

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	WHITE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER	DATE
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE):					SNAP (Food Stamp)	TEMPORARY ASSISTANCE
		YEAR	MONTH	2 X A MONTH	EVERY 2 WEEKS	WEEKLY		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eligibility Determination: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Paid								
SIGNATURE OF CENTER REPRESENTATIVE						DATE		