Keiki's Learning Center

Address: 213 & 212 S Parkway Ave. Battleground, WA 98604

Phone Numbers:

213: 360.342.8462

212: 360.342.8528

Registration Information

Today's Date:________________

Date Child Entered Care:________________ Date Child Left Care:_________________

Child's Full Name: ____

Name Used (Nickname):______________________Date of Birth:___________________

Contact Information

Parent/Guardian #1

Full Name:________________________________ Relationship to Child:_______________

Address:____________________________________ Social Security #:____-___-_____

City/ST/Zip:_________________________________Date of Birth:__________________

Cell Phone:__________________________ Home Number:_________________________

Employer:______________________________Work Number:______________________

Employer's Address:____

Employer's City/ST/Zip: ____

Email:____

Parent/Guardian #2

Full Name:_______________________________ Relationship to Child:_______________

Address:____________________________________ Social Security #:____-___-_____

City/ST/Zip:_________________________________Date of Birth:_________________

Cell Phone:_________________________ Home Number:__________________________

Employer:______________________________Work Number:_______________________

Employer's Address:____

Employer's City/ST/Zip: ____

Email:____

Medical Information

Doctor Information:

Name of Child's Physician or Clinic:_________________________ Phone:___________

Clinic Address/City/State: ____

Date of last exam:_____________________________

Dentist Information:(If none, when dentist will be assigned)______________________

Name of Child's Dentist or Clinic:___________________________ Phone:___________

Clinic Address/City/State:____

Date of last exam:_____________________________

Consent to Medical Care and Treatment of Minor Child

I give permission that my child, ____________________________ may be given first aid/emergency treatment by the child care licensee and or qualified staff at Keiki's Learning Center.

Parent/Guardian signature:_____________________________**Date:**_________

When I cannot be contacted, I authorize and consent to medical, surgical, hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Parent/Guardian signature:_____________________________**Date:**_________

Authorized Emergency Contacts

Child's Name______________________________ Date: ______________________

Parent Name: _____________________________ Parent Signature: __________________________

YOUR CHILD WILL ONLY BE RELEASED TO THOSE PEOPLE AUTHORIZED BY A PARENT OR GUARDIAN.

Please provide at least two local persons authorized to pick up your child **AT ANY TIME** and in case of emergency, illness, accident, late pick-up, or any other reason. Please list them in order of preference for us to contact.

Name____ Cell Phone: ___________________

Address: _______________________________________ City/St: _____ Home Phone: __________________

Relation to Child: ________________________ Work Phone; __________________

Name____ Cell Phone: ___________________

Address: _______________________________________ City/St: _____ Home Phone: __________________

Relation to Child: ________________________ Work Phone; __________________

Name____ Cell Phone: ___________________

Address: _______________________________________ City/St: _____ Home Phone: __________________

Relation to Child: ________________________ Work Phone; __________________

Keiki's Learning Center - Parent Agreement

Parents or Guardian must sign they have read and agree to the following guidelines of Keiki's Learning Center. Initial each line then sign and date at the bottom of the reverse side.

______**Registraion Forms:** I have filled out all forms completely, I understand I will update all information immediately in writing upon any changes.I understand an annual update with my signature is also required.

______**Parent Financial Contrast:** I have signed the Parent Financial Contract

______**Policies and Procedures**: The Directors or Assistant Director has explained the Center's Philosophy, program and facility.

______**Parent Handbook:** I have read the parent handbook completely and I understand all policies and procedures.

______**Pesticide Policy:** I have read the pesticide policy and understand I will be notified in advance of any procedures of the center.

______**Nondiscrimination Policy:** I have read the nondiscrimination policy.

______**Emeregency/Disaster Plan:** I have read the emergency/disaster plan.

______**Schedule & Absences:** My child's schedule is given to the Director or the Assistant Director upon enrollment. I will notify in writing any changes to my child's schedule immediately. I will notify the center if my child will be absent or when he/she will no longer attend.

______**Extra change of clothes:** I will provide an extra change of clothing for my child (multiple changes if my child is not fully potty trained) at all times.

______**Diapers & wipes:** I will provide all diapers , pull ups, and wipes for my child.

______**Pictures:** I give permission for pictures of my child taken and used for the following (circle all that applies) **projects, display in center, calendars.**

______**Parent communication:** I understand the center staff will communicate with me about my child's progress, issues, relating to my child's care and individual practices based on my child's individual needs. I understand if I need to speak to my child's teacher in more depth I will need to schedule a conference with the Director or Assistant Director.

______**Child Abuse Reporting Requirements:** I understand that Keiki's Learning Center's staff are mandated reporters and are required by Washington State Law to notify Child Protective Services or Local Law Enforcement of any suspected child abuse, neglect, or exploitation. I also understand or may not be notified of such a report, at the recommendation of Child Protective Services.

______**Illness:** I understand that if my child shows signs of illness (fever, rash, vomiting, diarrhea, lethargy, lice, etc...) he/she may be excluded from the center for 24 hours or a Doctor's note is brought to the center saying they can attend. If your child shows signs at home, I will keep them home and call the center to let them know.

______**Withdrawing or Terminating Care:** I understand if a two-week notice is not given I may not receive a refund.

______________________	______________________	______________
Parent Name Print	**Parent signature**	**Date**

Keiki's Learning Center- Parent Financial Contract

Monthly Rate	**Overtime Care**
Full Time Rate	**(10+hours- Additional Fee)**
Infants $1890.00	$44.50
Toddlers $1700.00	$40.00
Preschool 3 $1583.00 (**not potty trained**)	$33.00
Preschool $1533.00	$33.00
School Age $1386.00	$27.00

REGISTRATION FEE: $60.00 per child, upon enrollment, this is due every January and is Non-refundable

PRIVATE PAY: Keiki's Learning Center operates on a monthly payment system. Payments are due on the 1st and become late on the 5th of the month a $25.00 late payment will be added to your ledger if the account isn't paid by the 5th of each month. If the account isn't paid by the 10th of the month your care will be terminated until payment is paid in full unless prior arrangements have been made with the Director. Full-time rates are listed above, this is for anything over 5 hours up to 10 hours, if you are looking for part-time you will be charged the daily rate.

STATE PAYMENTS: You are required to pay your co-pay by the 1st of each month. If you do not pay for two months, your child's care will be terminated and reported to DSHS which may end your care with them until the balance is paid. If your child attends more than the authorized days, you will be required to pay the private pay rates.

OVERTIME CARE: WAC 170-295-2020 states that children can be in care for a maximum of 10 hours per day unless the parent's work schedule or commute to the center requires more than 10 hours. If your child attends more than 10 hours, there will be an additional fee added to your ledger for each day that care is provided over 10 hours.

STATE PAYMENT: If you receive your childcare subsidy from DSHS or Children's Administration, this fee will still be applied to your register, unless covered by DSHS or Children's Administration. Contact your case manager for approval.

LATE PICKUP FEE: The charge is $15.00 dollars for the fist minute and then $1.00 dollar per minute for every minute after 6:00 pm, for each child.

OPERATING HOURS: The center is open from 6:00 am to 6:00 pm, Monday through Friday.

VIEW ACCOUNT: You may view your account by clicking the ACCOUNTING button on the check-in computer.

PAYMENTS ACCEPTED: Our center accepts checks, cash, money orders, and credit/debit cards and you have the option to pay online at MyProcare.com you must have an e-mail on file, please see the office if this is an option you would like to do. There is a $30.00 charge for any NSF charges, and you will not be allowed to pay by check.

Collection Agency: If your account is left unpaid for 30 days it will be turned over to Solverity Collections they are located at 9707 NE 54th St. Vancouver, Washington 98662 their contact information is 360-604-8514, please keep in mind that Keiki's Learning Center will make every attempt to keep this from happening and will try everything we can to help you resolve this from happening but in some cases no matter what we do to help it may result to going to collections. Please keep in mind once it is turned over to collections, we can no longer accept payments from you or discuss your account, you will need to contact the collection agency.

WITHDRAWING FROM KEIKI' S: Keiki's Learning Center will no longer be giving refunds we operate on monthly tuition and it is up to you to finish out the month that has been paid for and forfeit the remaining balance. All personal items must be removed from the center within 30 days of termination or withdrawal, after which they will be donated to Keiki's Learning Center. If a refund is given Keiki's Learning has 30 days from the notice given to issue the refund whether in person or through the mail.

Crediting Accounts: Keiki's Learning Center will no longer be crediting for absent days, you are responsible for your monthly tuition whether in attendance or not. Keiki's Learning Center will credit for vacation days with proper two weeks' notice, without proper notice credit will not be given.

ADDITIONAL DAYS IF NEEDED ARE AS FOLLOWS:

Full Days (more than 5 hours)		Half Days (5 hours or less)
Infants	$90.00	N/A
Toddlers	$81.00	$41.00
Preschool 3 (Not Pottied Trained)	$75.00	$41.00
Preschool	$73.00	$37.00
School Age	$66.00	$33.00

____

Parent/Guardian Name   Signature   Date

Child's Name:____

Child Care Contract

Attendance Schedule:

Monday:	Arrive:________	Depart:________
Tuesday:	Arrive:________	Depart:________
Wednesday:	Arrive:________	Depart:________
Thursday:	Arrive:________	Depart:________
Friday:	Arrive:________	Depart:________

Notes:

A two-week notice is required for a schedule change or withdrawal from the Center. If a two week notice is not given, parents/guardians are still responsible for payment of the two weeks of childcare specified (unless the Director chooses not to have the notice) your schedule above is what you will be responsible for each month.

Keiki's Learning Center will no longer give credit for closure dates or absent dates, you will be responsible for your scheduled days tuition, remember you are paying for the spot. Keiki's Learning Center enrolls children according to your schedule so there is very limited space for add on days, we will do our best to accommodate your needs if possible.

Keiki's Learning Center does not hold spots for an extended amount of time ex: Summer Breaks, Winter Breaks, without payment you are responsible for two days a week in order for us to hold your spot. Without payment there is no guarantee your spot will be available when returning.

Keiki's Learning Center will offer a 10 day unpaid vacation each year. You will need to notify the Directors of your planned days of vacation with at least 2 weeks notice.

Late Payments

Payments are due on the 1st of each month and become late on the 5th at this time a late payment fee will be added to your account of $25.00 dollars if payment is not paid by the 20th Keiki's Learning Center will suspend your care until payment is made (for State parents we will red flag your account of no-payment) unless other arrangements have been made through the office.

Late Child pickup

If your child is picked up after our closing time, Keiki's Learning Center will charge $15 the first minute and $1 after each additional minute.

Overtime Care

A child is not allowed to be in care for more than 10 hrs a day, if your child is here for more than 10 hrs a overtime fee will be added to each additional day they are here.

____

Parent Signature Date

Certificate of Immunization Status (CIS)

Reviewed by:	Date:
Signed COE on File? ☐ Yes ☐ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X ______ Parent/Guardian Signature Date	X ______ Parent/Guardian Signature Required if Starting in Conditional Status Date

▲Required for School ● Required Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry						
●▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
●▲ DT or Td (Tetanus, Diphtheria)						
●▲ Hepatitis B						
● Hib (*Haemophilus influenzae type b*)						
●▲ IPV (Polio) (any combination of IPV/OPV)						
●▲ OPV (Polio)						
●▲ MMR (Measles, Mumps, Rubella)						
● PCV/PPSV (Pneumococcal)						
●▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
COVID-19						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐Polio (all 3 serotypes must show immunity)

▶

Licensed Health Care Provider Signature Date

▶

Printed Name

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name: ______ Signature: ______ Date: ______
If verified by school or child care staff the medical immunization records must be attached to this document.

Instructions for completing the Certificate of Immunization Status (CIS): Print the from the Immunization Information System (IIS) or fill it in by hand.

To print with the immunization information filled in:
Ask if your health care provider's office enters immunizations into the WA Immunization Information System (Washington's statewide registry). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.

To fill out the form by hand:
1. Print your child's name and birthdate, and sign your name where indicated on page one.
2. Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.
3. If your child had chickenpox (varicella) disease and not the vaccine, a health care provider must verify chickenpox disease to meet school requirements.
   - ☐ If your health care provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
   - ☐ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.
4. If your child can show positive immunity by blood test (titer), have your health care provider check the boxes for the appropriate disease in the Documentation of Disease Immunity section, and sign and date the form. You must provide lab reports with this CIS.
5. Provide proof of medically verified records, following the guidelines below.

Acceptable Medical Records
All vaccination records must be medically verified. Examples include:

- A Certificate of Immunization Status (CIS) form printed with the vaccination dates from the Washington State Immunization Information System (IIS), MyIR, or another state's IIS.
- A completed hardcopy CIS with a health care provider validation signature.
- A completed hardcopy CIS with attached vaccination records printed from a health care provider's electronic health record with a health care provider signature or stamp. The school administrator, nurse, or designee must verify the dates on the CIS have been accurately transcribed and provide a signature on the form.

Conditional Status
Children can enter and stay in school or child care in conditional status if they are catching up on required vaccines for school or child care entry. (Vaccine series doses are spread out among minimum intervals, so some children may have to wait a period of time before finishing their vaccinations. This means they may enter school while waiting for their next required vaccine dose). To enter school or child care in conditional status, a child must have all the vaccine doses they are eligible to receive before starting school or child care.

Students in conditional status may remain in school while waiting for the minimum valid date of the next vaccine dose plus another 30 days time to turn in documentation of vaccination. If a student is catching up on multiple vaccines, conditional status continues in a similar manner until all of the required vaccines are complete.

If the 30-day conditional period expires and documentation has not been given to the school or child care, then the student must be excluded from further attendance, per RCW 28A.210.120. Valid documentation includes evidence of immunity to the disease in question, medical records showing vaccination, or a completed certificate of exemption (COE) form.

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://www.cdc.gov/vaccines/terms/usvaccines.html

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Fluarix	Flu	Havrix	Hep A	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)
Adacel	Tdap	Flucelvax	Flu	Hiberix	Hib	Pediarix	DTaP + Hep B + IPV	RotaTeq	Rotavirus (PV5)
Afluria	Flu	FluLaval	Flu	HibTITER	Hib	PedvaxHIB	Hib	Tenivac	Td
Bexsero	MenB	FluMist	Flu	Ipol	IPV	Pentacel	DTaP + Hib +IPV	Trumenba	MenB
Boostrix	Tdap	Fluvirin	Flu	Infanrix	DTaP	Pneumovax	PPSV	Twinrix	Hep A + Hep B
Cervarix	2vHPV	Fluzone	Flu	Kinrix	DTaP + IPV	Prevnar	PCV	Vaqta	Hep A
Daptacel	DTaP	Gardasil	4vHPV	Menactra	MCV or MCV4	ProQuad	MMR + Varicella	Varivax	Varicella
Engerix-B	Hep B	Gardasil 9	9vHPV	Menomune	MPSV4	Recombivax HB	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

Allergy Action Plan

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: ______________________________ Date of Birth: ____________

ALLERGY TO: ____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is *not* exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.

***IMPORTANT:** Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

Doctor's Signature ______________________________ Date ____________

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: ______________________________ Phone Number: ____________

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

***EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.**

Health Care Provider and Parent Authorization for Self/Carry Self Administration

I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

Parent/Guardian's Signature ______________________________ Date ____________

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: ______________________ **Date of Birth**: ____________

ALLERGY TO: ______________________

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐ ______________________

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EPIPEN®
(Epinephrine) Auto-Injectors 0.3/0.15 mg
userguide

1 Pull off the blue safety release cap.

2 Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.

HOLD for 10 seconds

Call 911

3 Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit epipen.com.

The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐ ______________________

____

____

____

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- ☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)
- ☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- ☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- ☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR—Any household member receiving benefits can establish eligibility for all children in the household.	**Case Number or Identification Number**

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the SSN is not needed.

"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."

Signature of Adult	**Today's Date**	**Print Name of Adult Signing**
X______________________	____________	**Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN
Address	**City/State/Zip Code**	**Daytime Phone**

PART 6 – 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 ☐ Multi-Racial ☐ Native Hawaiian or 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 Basic Food, 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, 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; or

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

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

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on Basic Food/TANF/FDPIR.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free
☐ Reduced-Price
☐ Above-Scale

Total Income: $______________
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X____ ____________________
Signature of Institution's Representative **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.

EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.