

Iowa Eligibility Application

FFY 16-17

Complete one application per household. School Year 2016-2017

Part 1. Check all applicable boxes:

<input type="checkbox"/> school meals	<input type="checkbox"/> children in child care center	<input type="checkbox"/> children in child care home(HP)
<input type="checkbox"/> special milk (restrictions apply)	<input type="checkbox"/> Tier I home provider (HP)	Provider name: _____
	<input type="checkbox"/> Head Start/Even Start	

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. Run away Migrant Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

Name of household member with Case Number _____ List Case Number _____

Part 4. Children enrolled. REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.							OPTIONAL		Name of School/Head Start/ Child Care Center/Home
Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	ETHNICITY	RACE		
1.			<input type="checkbox"/>						
2.			<input type="checkbox"/>						
3.			<input type="checkbox"/>						
4.			<input type="checkbox"/>						
5.			<input type="checkbox"/>						

Part 5. Total Household Gross Income. DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3.
Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of <u>everyone</u> living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.				Gross Income: Report income by how often the household member is paid.				Other Monthly Payments or Income Received.		
Last Name	First Name	Age	Check if NO Income	Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			<input type="checkbox"/>							
2.			<input type="checkbox"/>							
3.			<input type="checkbox"/>							
4.			<input type="checkbox"/>							
5.			<input type="checkbox"/>							

Last four digits of my Social Security Number: X XX - XX - _____ I do not have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. For further information refer to the Privacy Act Statement in the parent letter.

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.

I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form _____

Signature of Adult Completing Form _____ Printed Name of Adult Completing Form _____ Date Signed _____

Address of Adult Completing Form _____ Town _____ ZIP Code _____ Work Phone _____ Home Phone _____ Cell Phone _____

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: \$ _____ Weekly Every 2 Weeks Twice Monthly Monthly Annually Household Size _____

Application Approved: <input type="checkbox"/> Income <input type="checkbox"/> Foster Child (free) <input type="checkbox"/> Head Start DOCUMENTATION REQUIRED	<input type="checkbox"/> FIP/Food Assistance <input type="checkbox"/> Homeless/Migrant/Runaway (Schools only)	CACFP HP ONLY: <input type="checkbox"/> Tier 1 Area (Provider's own children) <input type="checkbox"/> Tier 1 Income (All children) <input type="checkbox"/> Tier 1 Child (Tier 2 mixed)
Eligibility Determination: Application Denied: <input type="checkbox"/> Free Meals <input type="checkbox"/> Reduced Price Meals <input type="checkbox"/> Incomplete <input type="checkbox"/> Over income limits	<input type="checkbox"/> Free Milk	

Determining Official Signature _____ Effective Date _____

- Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 7/2016

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for food assistance or FIP, you may fill out an application at that time.

**Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2016 to 6-30-2017**

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$718
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
6	\$60,273	\$5,023	\$2,512	\$2,319	\$1,160
7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
For each additional family member add:	+ \$7,696	+ \$642	+ \$321	+ \$296	+ \$148

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a Food Assistance number, or Family Investment Program number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

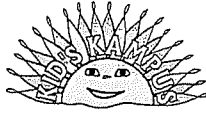
USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.



2017 PARENTAL EMERGENCY MEDICAL CONSENT-

Kid's Kampus Learning Center Inc.

Child's Name _____ Date of Birth _____

In the event that my child may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or dental care to the _____ Hospital and Dr. _____ or his/her designee to provide this care. In the event that my child (listed above) may require dental and/or surgical care, I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent. (For current parents enrolled already- yearly update)

Allergies _____ Present Medication(s) for my child _____

1. Mother/Guardian Name _____ Home # _____

Address _____ Cell # _____

City/ST/Zip _____ Place of Employment _____ Relationship to child _____

Work # _____ Mother's email address _____

2. Father/Guardian Name _____ Home # _____

Address _____ Cell # _____

City/ST/Zip _____ Place of Employment _____ Relationship to child _____

Work # _____ Father's email address _____

Please mark a * by the one phone number (above) for staff to call FIRST to reach a parent during the day.

3. First person to contact in case of an emergency if parent is unavailable, and are authorized to PICK UP Child

Name _____ Home # _____

Address _____ Cell # _____

City/ST/Zip _____ Place of Employment _____ Relationship to child _____

Work # _____

4. 2nd person to contact in case of an emergency if parent is unavailable, and are authorized to PICK UP Child

Name _____ Home # _____

Address _____ Cell # _____

City/ST/Zip _____ Place of Employment _____ Relationship to child _____

Work # _____

5. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with your child while in care at the center? Name _____ Do you have a copy for us _____

Child's Doctor's name(not a clinic name) _____ Phone # _____ Address _____

Child's Dentist's name(not a clinic name) _____ Phone # _____ Address _____

1. Does your child have permission to be transported in our vans for pre-authorized FIELD TRIPS (after your child turns 3 years old) ___Yes ___ No (You will sign off prior to each field trip)

2. Can your child be photographed for our face book /web page ___Yes ___ No

3. Can your child be videotaped with their class on our face book site ___Yes ___ No

Parent signature _____ Date _____