KID'S KAMPUS LEARNING CENTER INC.

Enrollment Form

Child's Name_________________ _______ ____________________
(First) (Middle) (Last)

Child's Address____
Date of Birth____________ Sex: M/F_____ Enrollment Date__________
Primary Language_________ Allergies______________
*Food exceptions______________________(*Ask the office for a Diet Modification Request Form for your doctor to fill out) Special Instructions____
* Note If your child has any special needs, please discuss with the director prior to enrollment.

Please list your child's normal schedule below so that we may schedule our staff's working hours correctly. If you need your child to come earlier or stay later - please let us know the day before so that we meet state requirements and our staff can adjust their schedule. Our fees are based on your child being in our care for no longer than 10 hours per day.

Monday	Tuesday	Wednesday	Thursday	Friday
__:__ to__:__	__:__to__:__	__:__ to__:__	__:__to__:__	__:__to__:__

The PAYMENT for tuition
* Leave a check in the front foyer box each **MONDAY** (Late fees are charged after Tuesday.)

Primary PAYMENT Contract: I was referred by:

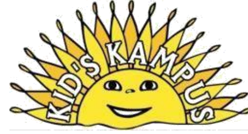
Name___________________________ Name of family____________________

Marital Status:

Married _____ Divorced _____ Single______ Separated _____ Widowed _____

___I have access to the online parent hand book **OR** ___I need a hard copy

Parent Signature________________________________ Date_____________________



Parent Contract Form

The following agreement is made between parent/guardian and Kid's Kampus Learning Center Inc for the child care services for:

Child's Name__________________________ Child's start date____________
The terms of this agreement are as follows: Weekly tuition $________________

- Enrollment Fee- $65.00 per child (plus first week's tuition to hold spot) **NON-REUNDABLE** We will credit you $5 on your account once you have downloaded the Daily Connect App. And responded to our first message.
- Annual Fall Preschool Fee
  _____$30.00 Preschool One or Preschool Two
  _____$20.00 prorated fee January through March
  _____ (no fee charged if child begins between April and the end of July)
- Late Payment Fees- Tuition is due each Monday.
  If not paid by Tuesday night add $5 per child. If not paid by Wednesday night the fee per child doubles. If not paid by Thursday night the fee per child triples Tuesday's fee again. *If not paid by Friday- your child can **NOT** return until payment is received.
- Full tuition fee is due each week, regardless of days missed for illness, vacation, holidays, or days the center is closed due to weather.
- We are closed at 6:00P.M. Our late pick up fee at 6:01 is $5 **per child** and an additional **$1 per minute per child after 6:01.**
- **If a check is returned from your bank there is a fee of $35.00.**
- The center is closed the following times: -New Year's Day*-Memorial Day -Fourth of July* -Labor Day -Staff in-service day the Friday before school starts -Thanksgiving and the Friday after -Christmas Day*
- (*If the holiday falls on a weekend, we will be closed the week day closest to it)
  On Christmas Eve we close at noon.
- This contract may be terminated by either parent/guardian or provider by giving a 2 week advance notice. Payment for child care services is due for that 2 week period, whether or not the child attends Kid's Kampus
- **Once a month my child ___can or ___cannot participate in chapel time**

I/we agree to abide by the written terms of this agreement

______________________________ _____________
Parent Signature Date

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 # _____________________________

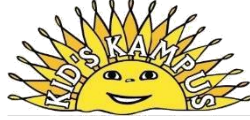
City/ST/Zip_____________________________ Place of Employment_________________ Relationship to child______________________ Work #____________________________

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
4. Parent signature ______________________________ Date ________________



Child's Physical Form

Kid's Kampus Learning Center Inc.

Child's Name________________ Date of Birth__________ Age_____

Address________________________ Home Phone_________________

Check illnesses child has had:
___Measles ____German Measles ____Strep Throat ___Scarlet Fever
___Mumps ____Chicken Pox ____Rheumatic Fever

Allergies to food____ Other Allergies____
This Child needs a Diet Modification Form ___yes ___no

Contact with tuberculosis ____Yes ___No
If tuberculin test given: Date_______ Results____________________
If chest X –rayed: Date_____________ Result_____________________

Any surgery, accidents or other illnesses or special problems:
____
Immunizations are up to date? ___Yes ___No

Comments/recommendations to the child care provider
____

The above named child has received all necessary immunizations, is in good health and able to participate in a child care center where the child to adult ratio will be :
4-1 Infant and Toddlers, 6-1 Two Year Olds, 8-1 Three year olds, Olds, 12-1 Four & Five Year or 15-1 School Agers.

Physicians signature_________________________ Date of exam_____________
Please return to: Kid's Kampus Learning Center 5150 Blairs Forest Way NE
Cedar Rapids, Iowa 52402

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* We also need an Iowa Department of Public Heath- Certificate of Immunization
(Many doctor offices will already have it on their computer for you!)

Iowa Department of Public Health
Certificate of Immunization

Name Last: ______________________ First: ____________ ____ Middle: ____________ ____ Date of Birth: ______________

Parent/Guardian: ____________________ Address: ____ Phone: (____)____________

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: ____ Date: ________________

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the “Total Doses Required” column.

Institution	Age	Vaccine	Total Doses Required
Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. **Routine vaccination begins at 2 months of age.**	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses; or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age, or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a 3 doses if the applicant received 2 doses before 12 months of age; or positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
	24 months and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 1 dose received when the applicant is 15 months of age or older. Hib vaccine is not indicated for persons 60 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 2 doses if the applicant received 1 dose before 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age. **Pneumococcal vaccine is not indicated for persons 60 months of age or older.**
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
	4 years of age and older	Diphtheria/Tetanus/ Pertussis [3, 4]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003.[2] DTaP is not indicated for persons 7 years of age and older, therefore, a tetanus-and diphtheria-containing vaccine should be used.
		Polio [6]	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003.[5]
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses if the applicant was born on or after July 1, 1994.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born before 2 doses received on or after 12 months of age if the applicant was born on or after September 15, 2003, unless the applicant has a reliable history of natural disease.[7]

1 Mumps vaccine may be included in measles/rubella-containing vaccine.
2 The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.
3 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.
4 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.
5 If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.
6 If both OPV and IPV were administered as part of the series, a total of 4 doses are required, regardless of the applicant’s current age.
7 Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4-weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.

Our center participates in the Child and Adult Food Program (just like Rockwell and other quality child care centers). Each family must fill out an Iowa Eligibility Application.

All families MUST fill out parts 4 & 6. Fill out part 5 by using the chart on the Iowa CACFP Child Care Center Parent/Guardian Letter (attached). Please find the number in your family and then go across to find the yearly gross salary. When you fill out your income, please fill out the last four of your social security number in the space provided. If you find out that you are OVER the Income Eligibility Guidelines- then you do NOT have to fill in your income- instead you can just write "*Over the limit*." **All families MUST fill out the child care enrollment form as well (even if you are not enrolling an infant).**

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*If you are on the Child Care Assistance Program, you must fill out section 3 with your Food Assistance case number (FIP). This number is usually 10 digits, the first being a letter followed by 9 numbers. Then fill out section 4.

If your child is a foster child, check the appropriate box in part 4, fill out and sign part 6.

Thank you for your time. This food program does directly affect the quality of our program for your child. It gives back money to use for nutritional food, education supplies, and quality programing.

We need EVERYONE to fill this out so that we can continue to provide quality care for your children!

Sincerely,
Shawn Hauskins, Aubree Herb, Stacy West, & Brenda Berg

Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 7/2018

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 7-1-2018 to 6-30-2019

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$22,459	$1,872	$936	$864	$ 432
2	$30,451	$2,538	$1,269	$1,172	$ 586
3	$38,443	$3,204	$1,602	$1,479	$ 740
4	$46,435	$3,870	$1,935	$1,786	$ 893
5	$54,427	$4,536	$2,268	$2,094	$1,047
6	$62,419	$5,202	$2,601	$2,401	$1,201
7	$70,411	$5,868	$2,934	$2,709	$1,355
8	$78,403	$6,534	$3,267	$3,016	$1,508
For each additional family member add:	+ $7,992	+ $666	+ $333	+ $308	+ $154

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.

Instructions for Completing Iowa Eligibility Application

Complete both sides of an application for each household.

All applicants should complete Part 1. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

FIP OR FOOD ASSISTANCE HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start, follow these instructions. **Part 3.** List one FIP or Food Assistance **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Part 4.** List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.
Part 5. Skip this section.
Part 6. Read the certification and complete this section.

HOMELESS, MIGRANT OR RUNAWAY, follow these instructions.
Part 2. For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.
Part 5. Skip this section.
Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.
Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.
Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.
Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income.
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.
Part 5. Follow these instructions to report total household income from last month.

- **Name:** List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- **Age:** List the age of each household member.
- **Check if No Income:** Put a mark in the box if the household member **does not** have an income.
- **Gross Income last month and how it was received:** Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, **or** monthly). List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.
- **Other Monthly Payments or Income:** Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report**: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.
- **Social Security Number:** If the application is being made on the basis of income, 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. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.

Iowa Eligibility Application

FFY 18-19

Complete one application per household. Fiscal Year 2018-2019

Part 1. Check all applicable boxes:
- ☐ school meals
- ☐ special milk (restrictions apply)
- ☐ children in child care center
- ☐ Tier I home provider (HP)
- ☐ Head Start/Even Start
- ☐ children in child care home(HP) Provider name:

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 (10 digits, include zeros). 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.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino
Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White

If ethnicity & race are not completed, the form will be completed based on visual observation

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

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 everyone 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.

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
				Gross Income: Report income by how often the household member is paid.				Other Monthly Payments or Income Received.		
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: **X XX - X X -** ___ ___ ___ ___ ☐ 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: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk
Application Denied: ☐ Incomplete ☐ Over income limits

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)
☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature | **Effective Date**

Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

May 2018

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	**Birthdate**	**Arrival**	**Departure**	**M**	**T**	**W**	**Th**	**F**	**S**	**S**	**B**	**AM Sn**	**Lu**	**PM Sn**	**D**	**E Sn**	**Ethnicity**	**Race**

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, the center's Program representative is required to note race/ethnicity on the basis of visual observation.

Infants only (0 to 12 months): ❑ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

❑ I will provide breastmilk for my infant. ❑ Yes ❑ No Center formula may be used to supplement feedings if necessary: ❑ Yes ❑ No

❑ I would like to breastfeed on site, if this option is available[1]. ❑ Yes ❑ No If yes, time(s)____________________

❑ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): ____________________

❑ I accept the center's formula for my infant. Name of iron-fortified formula: ____________________

❑ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: ____________________

❑ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

❑ I will provide solid foods for my infant[2]. The center may supplement with additional solid foods when my infant needs them: ❑ Yes ❑ No

Parent Signature______________________________Date:____________

Parent Signature______________________________Date:____________(Make any needed changes above, sign and date)

Parent Signature______________________________Date:____________(Make any needed changes above, sign and date)

[1]Ask your center if you can breastfeed on-site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

This institution is an equal opportunity provider.