



RAY & JOAN
Kroc
CORPS COMMUNITY CENTER

LEARNING ZONE BEFORE/AFTER SCHOOL APPLICATION 2023-2024

Instructions: **All requested information must be provided.** If the information is not known or does not apply, "unknown" or "none" is the required response. Please write legibly!!

BEFORE/AFTER SCHOOL PRICING

KROC CENTER MEMBERS:

Required deposit: *waived*
Before School care only: \$40 per week
After School care only: \$90 per week
Before and After School care: \$110 per week

KROC CENTER NON-MEMBERS:

Required deposit: \$25 per child
Before School care only: \$50 per week
After School care only: \$100 per week
Before and After School care: \$140 per week

Please select ONE of the following care options for 2023-2024:

- ☐ Before School care **ONLY** ☐ After School care **ONLY** ☐ Before AND After School care

FINANCIAL ASSISTANCE

Child receives PFCC (formerly called Title XX) state funding:

- ☐ Yes ☐ No

Child will receive free lunch at school for the 2023-2024 academic year:

- ☐ Yes ☐ No

Child will receive reduced lunch at school for the 2023-2024 academic year:

- ☐ Yes ☐ No

I am interested in receiving scholarship information and I qualify with an income rate at least 200% of the poverty level or with special circumstances.

- ☐ Yes ☐ No

Welcome to the 2023-24 Learning Zone!

Our first day will be Wednesday, August 23 and our hours are as follows:

Before School: 6:30am-8:00am, with transportation provided to each school

After School hours: Bus Arrival - 6:00pm

Morning Drop-Off will be at the Art Door on the NORTH-EAST corner of the building, near the glass-walled room. Breakfast will be served between 7-7:30am. We cannot serve breakfast past 7:30, so please make sure to have your child here by that time or plan to provide them breakfast at home. One bus will pick everyone up at 8:00 and transport them to their respective schools.

After-School Pick-Up can take place in two ways. You may pull into the North circle drive and call the front desk (419-281-8001) and we will walk them out to you. Or, you may park, walk inside, check in at the desk and they will contact us to bring your child out. You may pick your child up at any time before 6:00. Please make sure to keep your emergency contact list up to date. *We will check IDs as needed.*

Programming: In addition to help with homework and a healthy snack, we will be offering many different things this school year! We have several STEAM activities planned. We will have a new SEL curriculum that teachers will be implementing in their classrooms. We will have Waterparks Days, yoga, fitness, and rec, sewing and art opportunities!

ALLERGIES

While we provide snack each day for each child, we will be **PEANUT FREE** this school year as we have several children who have severe peanut allergies. Please **DO NOT** send any snacks with your child. Lunch boxes will not be allowed into the classrooms after school to prevent any possible peanut exposure (they will remain in hallway cubbies). Thank you for your understanding and help in keeping all our kids safe!

Communication: You can expect occasional emails throughout the school year, but most of our communication will be through the free app REMIND.

If you don't already have REMIND, please download it.

Join our class "**Learning Zone 23-24**" by texting "**@38fbb8**" to the number **81010**.

Payment:

Pay *weekly* over the phone or in person.

Statements will be sent home each Thursday with **payment due each FRIDAY** for the coming week.

The \$25.00 deposit for non-Kroc members is due immediately if not already paid.

First payment is due Friday, August 18th.

Bussing: Please make sure that you have completed the Opt-In bussing form which can be found on the Ashland City Schools website or by following this link:

<https://docs.google.com/forms/d/e/1FAIpQLSc6aLPTqI9QPUnGpLzKFblalt0NYbUomVSGNTJyILyfOB7P8g/viewform>

Reagan Walkers: Our Reagan students ride the bus in the morning but are met by two Learning Zone Teachers after school and walked to the Kroc. Please remember that we walk in all weather, and it is encouraged to bring labeled raincoats, umbrellas, snow or rainboots. We always carry extra hats and gloves for extra cold days if you forget!

Please remember to sign up for REMIND and be watching for more details as we get closer to the first day of school! If you have any questions, please don't hesitate to ask. We are looking forward to spending this time with your children!

With excitement and anticipation,

Dolores Seidel

Learning Zone Director

dolores.seidel@use.salvationarmy.org

419-281-8001

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name #1				Relationship to Child	
Home Address <input type="checkbox"/> Same as Child's				Home Telephone Number <input type="checkbox"/> Same as Child's	
City				State	
City				Zip	
Email Address (if applicable)				Cell Phone (if applicable)	
Parent's Work/School Name				Parent's Work/School Telephone Number	
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2				Relationship to Child	
Home Address <input type="checkbox"/> Same as Child's				Home Telephone Number <input type="checkbox"/> Same as Child's	
City				State	
City				Zip	
Email Address (if applicable)				Cell Phone	
Parent's Work/School Name				Parent's Work/School Telephone Number	
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email Where can you be reached while your child is in this program/home?					
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State		City	
City		State		City	
Telephone Number		Relationship to Child		Telephone Number	
Telephone Number		Relationship to Child		Telephone Number	
Other numbers where emergency contact can be reached (if applicable)				Other numbers where emergency contact can be reached (if applicable)	
Name of Physician or Clinic/Hospital					
Street Address					
City		State		Telephone Number	

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following:)	
The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every ____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport	OR	Do Not Give <u>Permission</u> to Transport
Program or Home Name has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.	Do not sign both	Program or Home Name does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature _____ Date _____		Parent's Signature _____ Date _____

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No (check one)	
This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.	
Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.			
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Waivers (Please read and initial/sign where appropriate.)

The Salvation Army Ray and Joan Kroc Corps Community Center and any of our partner organizations may use the above-listed participant's photo for promotional purposes.

_____ Yes, I give permission for my child's photo to be used for the above mentioned.

_____ No, I do not give permission for the use of my child's photo.

Student safety is our top priority. Students are expected to follow all Kroc Center rules including, but not limited to: keeping hands and feet to themselves, listening to all instructions, and staying with the group. I understand that if my child does not adhere to these rules, disciplinary consequences will occur. Repeat offenses or more serious acts such as fighting, theft, and possession of weapons/illegal substances will result in immediate suspension or expulsion, necessitating removal from the program. An authorized adult is responsible for picking him/her up immediately.

_____ I understand the behavioral policies set forth by RJKCCC.

Transportation from student's school to the Kroc Center:

AMS: Ashland City School Transportation

Edison: Ashland City School Transportation

Taft: Ashland City School Transportation

Reagan: Kroc Center Staff (walker doors)

_____ I understand that I am responsible to communicate with my child's school the method of transportation necessary.

No refunds are given unless the program is canceled by the Kroc Center. If you cancel your child's registration less than 30 days from the start of the program, a refund minus a \$25.00 administrative fee will be refunded. If canceled after 30 days, no refund will be given. No credits or prorated credits will be issued for missed days due to illness, partial attendance, behavior issues, or any other reason.

By signing below, I acknowledge, understand, and agree to the Kroc Center policies regarding payment and cancellations.

Parent/Guardian #1 Signature: _____

Date: _____

Parent/Guardian #2 Signature: _____

Date: _____

I (we) agree to the following: (1) member and any guests in his/her party will abide by the terms of this Agreement at all times during the period of membership and will comply with all rules and regulations posted or otherwise communicated to member, (2) in case of illness or injury, The Salvation Army Kroc Center is authorized to secure emergency medical treatment at the member's expense, (3) The Salvation Army Kroc Center reserves the right to remove from the facility or terminate the membership of any member who fails to comply with any posted rules and regulations or otherwise breaches the terms of this Agreement, in which case member will not be entitled to a refund of dues, (4) membership rights are not transferable, and (5) grant permission for The Salvation Army Kroc Center to make visual recordings of all individuals listed on this form and to use the image, voice and/or likeness of all individuals included in this application form with any publicity or promotional materials created for The Salvation Army Kroc Center.

Use of the facilities and equipment at The Salvation Army Kroc Center may involve risk of bodily injury or property damage and members agree to assume any such risks. Members further understand that it is up to them to consult physicians and other professionals to make sure that they can safely participate in activities and events at The Salvation Army Kroc Center. I understand and agree that by signing this Agreement, I am giving up my (or the minor for whom I sign) right to make any claim against The Salvation Army, its agents, employees and volunteers, including the right to sue them, for bodily injury or property damage or any other loss that I might suffer while using The Salvation Army Kroc Center facilities and services, except as limited by law.

By signing this document, my child and I (we) agree to the following terms: In case of illness or accident, The Salvation Army Kroc Center is authorized to secure emergency medical treatment at our expense. The Salvation Army Kroc Center reserves the right to dismiss any member who does not show respect for the facility, including, but not limited to: property, equipment, policies, other members, and staff. Members who are dismissed will not be given a refund of their membership fee.

My child will faithfully abide by the Policies, Rules, and Regulations of The Salvation Army Kroc Center. My child will do their best to live up to them and be an active and loyal participant. My child understands that this class/program enrollment is nontransferable.

In consideration of the participation in programs administered and conducted by The Salvation Army Kroc Center and/or use of facilities owned by The Salvation Army Kroc Center, the undersigned, on behalf of himself, herself or themselves, and all successors, heirs, assigns, and representatives does (do) hereby fully release and forever discharge The Salvation Army Kroc Center and its trustees, officers, directors, employees, agents, representatives, and affiliates ("Released Persons") from any and all liability, damages, demands, claims, actions and causes of action of any kind or description whatsoever, whether arising out of contract, tort or otherwise, in law or in equity, which the undersigned, on behalf of himself, herself or themselves, and all successors, heirs, assigns, and representatives may now have or may in the future have against The Salvation Army Kroc Center and the Released Persons, arising from participation in any program that was administered or conducted by The Salvation Army Kroc Center or the use of its facilities, including acts presently unknown but committed prior to the date of the execution of this Agreement.

I understand that the use of The Salvation Army Kroc Center, and participation in The Salvation Army Kroc Center activities and events, may involve the risk of bodily injury including death, as well as property damage. I agree to assume all such risks and all other risks associated with such use and participation. I understand that it is up to me to consult a physician or other healthcare professional(s) to ensure that I can safely use The Salvation Army Kroc Center, and/or participate in its activities and events.

I further understand and acknowledge the contagious nature of COVID-19 and agree to assume the risk of any injuries, including death, that may be sustained by me, my child(ren) and/or any other member(s) of my household in connection with the use of The Salvation Army Kroc Center or participation in any of its activities.

COVID-19 is an infectious disease and individuals with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Furthermore, these symptoms may appear 2-14 days after exposure to the virus, and include, but are not limited to, the following:

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle pain
- Sore throat
- New loss of taste or smell
- Nausea
- Vomiting
- Diarrhea

I represent and warrant that neither myself, my child(ren), nor any other member(s) of my household will enter The Salvation Army Kroc Center and/or participate in activities at The Salvation Army Kroc Center until after at least 14 days will have passed since last exhibiting any of the above symptoms or any other symptoms which have now or may in the future be identified, by a competent governmental authority, as being related to COVID-19.

Further, I agree to indemnify, hold harmless, assume liability for and defend The Salvation Army Kroc Center, and the Released Persons from all costs and expenses including, but not limited to, attorneys' fees, reasonable investigative and discovery costs, court costs, and any other sums which The Salvation Army Kroc Center, the Released Persons may pay or become obligated to pay for injury, including death, to persons or damage to property resulting from my, my child(ren) and/or any other member(s) of my household's use of said premises or from actions or omissions arising from any cause, except for matters caused by the gross negligence or willful misconduct of The Salvation Army Kroc Center or the Released Persons while acting within the scope of duties of such relationship to The Salvation Army Kroc Center.

If any term or provision hereof is invalid, illegal or unenforceable, the invalid, illegal or unenforceable term or provision shall be stricken only to the minimal extent necessary, and the remaining terms and provisions hereof shall remain unimpaired. No provision hereof may be waived except expressly in a writing signed by The Salvation Army Kroc Center.

If a member is under the age of 18 years old, a parent/guardian must sign this Agreement on their behalf.

I acknowledge that I have read and fully understand this Agreement and that I have been given an opportunity to ask questions and have such questions answered.

The undersigned has signed this Assumption of Risk, Release and Waiver of Liability, and Indemnity Agreement on the date listed below.

Child's Name (please print): _____ Date: _____

Parent's Name (please print): _____ Date: _____

Parent's Signature: _____

Ohio Department of Job and Family Services
ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s) Kroc Center Chapel, Kroc WaterPark, Reagan Playground, Kroc Center Outdoor Property	
Date of Permission <i>(valid for one year)</i> 8/23/2023	
Mode of Transportation <i>(walking, school bus, public transportation, parent vehicles, provider vehicle and driver)</i> Walking	
During this trip children will have access to water that is 18 inches or more in depth. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (if yes, a swimming permission slip is required)	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

Ohio Department of Job and Family Services
**PERMISSION TO PARTICIPATE IN WATER AND SWIMMING ACTIVITIES
FOR CHILD CARE**

<p>Written parental permission is required for the water activities your child will be engaging in when: <i>(check all that apply for this activity)</i></p> <p><input type="checkbox"/> Water is directly accessible to child (no water activities planned) <input checked="" type="checkbox"/> Child swimming or playing in water 18 inches or more in depth <input type="checkbox"/> Infants and toddlers using wading pools</p>	
<p>The program is providing additional adults or child care staff members that exceed the licensing ratio requirements for the water/swimming activity. <i>(The program is to meet the minimum ratio requirements outlined in rule).</i></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Swim Site Kroc Center Waterpark</p>	
<p>Date(s) 08/23/2023 - 08/23/2024</p>	
<p>Departure/Arrival Times from Program varies</p>	
<p>Mode of Transportation <i>(parents driving, provider vehicle, public transportation, school bus, etc.)</i> walking</p>	
<p>I give permission for my child to participate in the swimming/water activity listed above.</p>	
Child's Name	Child's Date of Birth
<p>My child is a <input type="checkbox"/> Swimmer <input type="checkbox"/> Non swimmer</p>	
Parent's Signature	Date

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name (Last)	(First)	Nickname (If any)
<i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. (Check all that apply) How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check all of the words that best describe your child's personality and behavior

- ☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.	
What might you and/or your child be anxious about as he/she starts in this program?	
What are you and/or your child excited about as he/she starts in this program?	
What are your expectations of this program?	
What other information would be helpful for the staff caring for your child to know?	
Parent/Guardian's Signature	Date

Child's Name _____ Parent Signature _____ Date _____

ACADEMIC INFORMATION

In order to best serve your child and help meet their academic goals, we would like permission to be in communication with your child's teacher and/or the school liaison.

___ Yes, I give permission for the Learning Zone staff to contact my child's teacher.

___ No, I do not give permission for the Learning Zone staff to contact my child's teacher.

___ Yes, I give permission for the Learning Zone staff to contact my child's school liaison.

___ No, I do not give permission for the Learning Zone staff to contact my child's liaison.

Teacher's Name _____

Teacher's Email _____

Please initial one:

___ I give permission for the Learning Zone to photocopy my child's test results and important academic information.

___ I DO NOT give permission for the Learning Zone to photocopy my child's test results and important academic information.

IEP - Individualized Education Plan

Does your child have an IEP? YES NO

If yes, please attach or email a copy of their IEP

OR initial:

_____ I give permission for the Learning Zone Director to request a copy of my child's IEP from the school.

GOAL SETTING

Please list two goals that you would like for your child to work on this year? The goals can be academic, behavior or social emotional.

1. _____

2. _____

What are your child's strengths? _____

What are your child's weaknesses? _____

On the back of this paper, tell me in a million words or less, if there is anything else we should know about your child.

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2022-2023

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME		CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation)	PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.			
PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER			Check type of benefit: <input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)			
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	<input type="checkbox"/>	CASE NO.	_____	
1.			<input type="checkbox"/>	CASE NO.	_____	
2.			<input type="checkbox"/>	CASE NO.	_____	
3.			<input type="checkbox"/>	CASE NO.	_____	
4.			<input type="checkbox"/>	CASE NO.	_____	

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ amount / how often	\$ amount / how often	\$ amount / how often	\$ amount / how often
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> (Check if applicable) I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

American Indian or Alaska Native	Asian	Black or African American
Native Hawaiian or Other Pacific Islander	White	Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

State Distribution: June 2022

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion: Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12		Application Certified/Categorized as: <input type="checkbox"/> FREE , based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household size and income <input type="checkbox"/> Foster Child <input type="checkbox"/> REDUCED , based on Household size and income
Total Household Size: _____ Total Household Income: \$ _____ Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year	<input type="checkbox"/> PAID , based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information	

Signature of Sponsor / Center Representative

Date Sponsor Certified/Categorized Form

Effective Date

Expiration Date

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

(From the first of month of date signed)

(Valid until last day of month in which form was signed one year earlier)

HOUSEHOLD LETTER - Dear Parent or Guardian

Please help us comply with the requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. **The completion of the income eligibility application is optional.** Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits. An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced-price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (*denotes required info)

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Attach documentation to show foster child status.

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.**PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.**

- Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.
- Check the box for any person listed as a household member (including children) that has no income.
- For each household member, list each type of income received during the last month and list how often the money was received.
 - Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
 - List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
 - List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
 - List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

- * All applications must have the signature of an adult household member.
- * The adult signing the application must also date the form.
- * Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

NON-DISCRIMINATION 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: [How to File a Complaint](#), 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. This institution is an equal opportunity provider.

REDUCED INCOME ELIGIBILITY GUIDELINES

Effective from July 1, 2022 through June 30, 2023. Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	25,142	2,096	1,048	967	484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
Additional member	+8,732	+728	+364	+336	+168