



# Enrollment Form

All forms must be completed and on file at the Center **on or before** your child's first day of attendance.

Today's Date: \_\_\_/\_\_\_/\_\_\_

(Office use only) Enrollment date: \_\_\_/\_\_\_/\_\_\_

Child's Name: \_\_\_\_\_ Child's Social Security # \_\_\_-\_\_\_-\_\_\_  
(First) (Middle) (Last)

Child's Nickname: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Gender: M / F

Please list approximate times the child will usually arrive and depart from the Center:

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival					
Departure					

## Custodial Parent/Guardian Information

Name: \_\_\_\_\_  
 Relationship to child: \_\_\_\_\_  
 Home address: \_\_\_\_\_  
(Street address)  
 \_\_\_\_\_  
(City) (State) (Zip)

Name: \_\_\_\_\_  
 Relationship to child: \_\_\_\_\_  
 Home address: \_\_\_\_\_  
(Street address)  
 \_\_\_\_\_  
(City) (State) (Zip)

Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Cell Phone Carrier: \_\_\_\_\_  
(This info is needed for the purpose of messaging w/our ProCare app)  
 Email: \_\_\_\_\_  
 Work hours: from \_\_\_:\_\_\_ to \_\_\_:\_\_\_  
 Work Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Cell Phone Carrier: \_\_\_\_\_  
(This info is needed for the purpose of messaging w/our ProCare app)  
 Email: \_\_\_\_\_  
 Work hours: from \_\_\_:\_\_\_ to \_\_\_:\_\_\_  
 Work Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_

Parents are:  Single  Married  Divorced  Separated  
 If divorced, who has custody?  Mother  Father  Both  Guardian:  
 Child's primary residence is with:  Mother  Father  Both  Guardian:  
 Is the non-custodial parent authorized to pick-up the child?  Yes  No (If no, please provide a copy of court custody papers.)

## Emergency Contact Information/Authorized Pick-Up

Please provide the following information on **at least two** responsible, non-custodial, local persons to contact in an emergency if the parent or guardian cannot be reached. We cannot release a child to anyone without **written** consent from a parent/guardian.

Name	Relationship to the child	Address* <small>(*Required for emergency contacts)</small>	Work/Cell Phone	Should be called in an emergency		Is authorized to pick up this child	
				Yes	No	Yes	No
				Yes	No	Yes	No
				Yes	No	Yes	No
				Yes	No	Yes	No

Any person picking up the child who is unknown to Center staff is required to show a picture ID

## Medical Information

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*A copy of your child's immunization record must be on file at the Center.  
Records must be updated after each series of immunizations.*

Child's Name: \_\_\_\_\_  
(First) (Last)

Name of Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Street address) (City) (State) (Zip)

Name of Child's Dentist: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Street address) (City) (State) (Zip)

Please list any allergies (including food, medicinal, seasonal, chemical, etc.) that your child has been diagnosed with. \_\_\_\_\_

Special Diet / Restrictions (vegan, vegetarian, no meat/pork, please be specific) \_\_\_\_\_

## Medical History

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Please list dates of diagnosis on all that apply:  None apply

___/___/___ Cancer	___/___/___ Hemophilia	___/___/___ Leukemia
___/___/___ Chicken Pox	___/___/___ Hepatitis B	___/___/___ Measles
___/___/___ Defective Heart	___/___/___ Hepatitis C	___/___/___ Mumps
___/___/___ Diabetes	___/___/___ HIV/AIDS	___/___/___ Tuberculosis
___/___/___ Epilepsy	___/___/___ Hypoglycemia	

Please check all that apply:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Frequent colds             | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Bed wetting     | <input type="checkbox"/> Frequent ear infections    | <input type="checkbox"/> Sun sensitivity |
| <input type="checkbox"/> Biting          | <input type="checkbox"/> Frequent throat infections | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Other: _____               |  |

## Emergency Medical/First Aid Consent

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I, parent/guardian of \_\_\_\_\_, authorize  
(child's first & last name)

Kiddie Campus to seek emergency medical care for my child. Such care may include transportation to and from the hospital, medical care from a licensed physician in the event that a parent/guardian cannot be reached, as well as first aid treatment by Center staff.

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While it is understood that reasonable precautions will be taken by the Center staff to prevent accident or injury to my child while in their care, I will not hold them legally responsible for such accident or injury.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## Permission/Acknowledgement

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Child's Name: \_\_\_\_\_  
(First) (Last)

- Yes  No I authorize Kiddie Campus to apply *Equate Kids Sunscreen Continuous Spray – Broad Spectrum SPF 50* sunscreen onto my child as needed for the \_\_\_\_\_ - \_\_\_\_\_ school year.
- Yes  No I authorize Kiddie Campus to apply *Off! Family Care Insect Repellent* onto my child as needed for the \_\_\_\_\_ - \_\_\_\_\_ school year.
- Yes  No I authorize my child to be photographed and/or videotaped for promotional uses and special events. I understand that my child's photograph may be viewed in the form of posters, television ads or news stories, and the Center's Facebook page and/or promotional websites.
- Yes  No I authorize Kiddie Campus staff to include my child in nature walks outside of the facility.
- Yes  No I authorize the Center to post my child's allergy/medical alert in his/her assigned classroom, in the kitchen, and other areas as needed. I understand that this information will be posted to ensure all staff members are aware of my child's allergy/medical needs.
- Yes  No I authorize the Center to transport my child in instances of unforeseen emergency situations that require relocation from the Center's facility.
- Yes  No I authorize Kiddie Campus to administer Acetaminophen to my child after I have been notified of the need and have given my verbal permission. I understand that I am responsible for providing this and completing a Medication Request Form prior to it being administered.
- Yes  No I authorize the Center to administer the Ages and Stages developmental screening to my child for the purpose of determining the progression of my child's skills and milestones. I understand that the results of the screening may indicate that a referral for further evaluation is needed to determine the best course of action to take to ensure my child's developmental needs are being met.

I have received the following information from Kiddie Campus Child Care Center:

- Yes  No AR Kids 1<sup>st</sup>
- Yes  No Medical homes for children
- Yes  No Positive Parenting Tips
- Yes  No MyPlate
- Yes  No Stages of Play
- Yes  No Facts About Physical Activity
- Yes  No Shaken Baby Syndrome (Infants)
- Yes  No AR Kindergarten Readiness Indicators (3-5 yrs)

**All applicable items  
are included in your  
enrollment packet.**

- I have read and understand the policies and procedures included in Kiddie Campus' Family Handbook for the \_\_\_\_\_ - \_\_\_\_\_ school year.

- I have read and understand Kiddie Campus' Behavior Guidance Policy as it is outlined in the Family Handbook.
- I understand that I may request a meeting/conference anytime with my child's teacher and/or the Center's administration to discuss any concerns I have regarding my child.
- I understand that DHS Licensing personnel, child maltreatment investigators, law enforcement, and/or AR Better Beginnings evaluators may interview my child for investigative purposes and/or view my child's file in an effort to determine the Center's compliance with licensing and quality standards. I further understand that this does not require parental notice or permission.
- I understand that the licensing compliance reports for Kiddie Campus are available to view upon request for the past 3 years.
- I understand my child's photograph may be taken by teachers and/or other parents during special events and used for classroom purposes such as cubby labels, wall displays, teacher-made books and portfolios. I further understand that my child's picture may be shared with me through ProCare.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

***When applicable, both custodial parents are required to sign this page.***

*By signing this page, you are acknowledging consent for, knowledge of, and/or receipt of the above sections that have you have marked.*



# Developmental Information Survey

## Preschool

Child's Name: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

### **Social Information**

Child's Siblings: Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Types & names of family pets: \_\_\_\_\_

Nationality: \_\_\_\_\_ Religious preference: \_\_\_\_\_

Please describe who has cared for your child other than parents? (Please state whether the caregiver was an adult or teenager.) \_\_\_\_\_

Has the child had prior group play experience? \_\_\_No \_\_\_ Yes: Please describe: \_\_\_\_\_

### **Birth History**

Type of birth: Normal:  Yes  No Premature:  No  Yes: How many weeks? \_\_\_\_\_

Complications? \_\_\_\_\_

Birth weight: \_\_\_\_\_ Length: \_\_\_\_\_ Head circumference: \_\_\_\_\_

Does your child have any birth marks?  Yes  No If yes, please describe (size & location): \_\_\_\_\_

### **Developmental Information**

Age your child began: Sitting up on own \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_

Is your child a good climber?  Yes  No Does s/he fall easily?  Yes  No

Can your child dress him/herself?  Yes  No Undress self?  Yes  No

Age your child began coherent talking: \_\_\_\_\_ Does s/he use  Words?  Sentences?

What language(s) do you speak with your child at home? \_\_\_\_\_

Please describe your child's favorite game: \_\_\_\_\_

Favorite toy/activity: \_\_\_\_\_

Favorite book/story: \_\_\_\_\_

Favorite person(s): \_\_\_\_\_

Does your child have any particular habits (thumb-sucking, nail-biting, etc.)?  No  Yes:

Please describe \_\_\_\_\_

Does your child have any fears that you know of?  No  Yes: Please describe \_\_\_\_\_

When your child seems upset or unhappy, what seems to comfort him/her? \_\_\_\_\_

Please list any allergies (other than food) that your child has (insect bites/stings, medication, etc.) and the type of reaction. *This should ALSO be noted on the Medical Report.*

Does your child attempt to hold a pencil correctly?  Yes  No Scissors?  Yes  No

How high can your child count with no mistakes? \_\_\_\_\_

Does your child recognize the letters in his/her name?  Yes  No



How do you get your child to sleep? \_\_\_\_\_

Does your child need a security item?  No  Yes: Please describe \_\_\_\_\_

Does your child need a pacifier?  No  Yes: What type? \_\_\_\_\_

## **Eating**

What time does your child usually eat? Breakfast \_\_:\_\_ Lunch \_\_:\_\_ Dinner \_\_:\_\_

Does your child feed him/herself?  No  Yes:  With fingers  With spoon  With fork

What are your child's favorite foods? \_\_\_\_\_

What foods are refused? \_\_\_\_\_

List any foods that have caused problems (allergy, choking, etc.):

*\*\*These should **ALSO** be noted on the Medical Report*

Food	Describe the problem

## **Other Information**

Please describe any important cultural celebrations that your family participates in: \_\_\_\_\_

What are some of your goals and dreams for your child? \_\_\_\_\_

What are some things you hope your child will learn or experience while in our program?

Please list any other important information or concerns that you feel our caregivers should know about:

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# ENROLLMENT, TUITION & OTHER FEES CONTRACT

Child's Name: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Fees:

- Registration Fee of \$100 (non-refundable)
- Operational Fee of \$50/month (includes materials, equipment, cleaning, and insurance)
- Weekly tuition payment of \$250.00/week (due on the Friday of the week before services are rendered)

### Forms of Payment:

- ProCare Tuition Express (\*\*Preferred) (Please see information below or pay through ProCare app.)
- Check
- DHS Childcare Assistance/Essential Workers/TEA program
  - DHS will pay \$ \_\_\_\_\_ per week. Parent/Guardian co-pay is \$ \_\_\_\_\_ per week.
  - Operational fee is \$50 per month.
  - My total payment based on the above amounts is \$ \_\_\_\_\_ per week.
  - I agree to pay this using the above-marked method.

### Please initial each statement:

- \_\_\_\_ I agree to drop off my child by 10:00am each day and understand that if I am later than this time my child will not be able to stay at the Center without prior consent from a member of the Leadership Team.
- \_\_\_\_ I agree to provide extra clothes, diapers and wipes for my child and replenish them when needed.
- \_\_\_\_ I understand that Kiddie Campus provides formula, milk, and baby food for all infants. If my child does not use the brand that the Center provides, I agree that I must provide them myself.
- \_\_\_\_ I agree to be responsible to pay for the agreed upon tuition payments and fees stated in this contract.
- \_\_\_\_ I agree to pay the tuition payment by Friday prior to the week in which services are rendered.
- \_\_\_\_ I understand that if payment is not made as scheduled, I am subject to a late fee of \$10.00.
- \_\_\_\_ I understand I am subject to a \$35.00 fee assessed for a returned payment. If more than one payment is returned, this method of payment will no longer be accepted and payment must therefore be made by bank check, or money order.
- \_\_\_\_ Late or returned payments more than four times in one calendar year may be subject to termination of enrollment.
- \_\_\_\_ I understand that scheduled days are established by Kiddie Campus. Tuition is not reduced for absences, family vacation time, and holiday closures or during inclement weather situations.
- \_\_\_\_ I understand that Kiddie Campus reserves the right to adjust tuition rates with at least 30 days written notice to parents.
- \_\_\_\_ I agree to pay a late pick up fee of \$1.00 for every minute after 6:00pm until I arrive.
- \_\_\_\_ I understand that in the event of collection action and/or lawsuit, I will be responsible to pay all collection fees, attorney's fees, and any other cost incurred by Kiddie Campus to collect what I owe.
- \_\_\_\_ I understand that enrollment of my child is subject to a two-week trial period. After the trial period, if I am to disenroll my child, I understand that I must give a two-week notice that is paid in full.
- \_\_\_\_ I have read and understand the disenrollment policies stated in the Family Handbook. I further understand that either myself or Kiddie Campus may terminate this contract by giving a two-week notice.

If any provisions of this contract or Family Handbook are held invalid or unenforceable, it should be ineffective only to the extent of the invalidity, without effecting or impairing the enforceability of the remainder of the contract or policy.

By signing this agreement, I understand, and I will abide by the terms and conditions for attending this childcare facility.

Parent / Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Kiddie Campus Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

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**CHILD CARE FOOD PROGRAM  
ENROLLMENT FORM**

Provider's Initial: _____  Date: _____
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To be completed by Parent or Guardian

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The mealtime patterns and the daily menus should always be posted and available for parents. If you have question, comments, or would like to learn more about the Child and Adult Care Food Program, contact our office at (505) 682-8869.

\_\_\_\_\_  
Name of Day Care Facility Telephone #

\_\_\_\_\_  
Address City State Zip Code

**The following information is required by USDA Federal Regulation (CFR 226.15(e)(2)).**

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well-balanced meals/snacks to day care children.

**My Child(ren) will be served the following meals:**

Breakfast:  AM Snack:  Lunch:  PM Snack:  Supper:  Late Snack:

Please Print Child(ren)'s Information						
First Name	Last Name	Age	Birthdate	Hours of Care	Days of Week	Gender
				From: To:	Sat. <input type="checkbox"/> Tue. <input type="checkbox"/> Fri. <input type="checkbox"/> Sun. <input type="checkbox"/> Wed. <input type="checkbox"/> Mon. <input type="checkbox"/> Thur. <input type="checkbox"/>	
				From: To:	Sat. <input type="checkbox"/> Tue. <input type="checkbox"/> Fri. <input type="checkbox"/> Sun. <input type="checkbox"/> Wed. <input type="checkbox"/> Mon. <input type="checkbox"/> Thur. <input type="checkbox"/>	
				From: To:	Sat. <input type="checkbox"/> Tue. <input type="checkbox"/> Fri. <input type="checkbox"/> Sun. <input type="checkbox"/> Wed. <input type="checkbox"/> Mon. <input type="checkbox"/> Thur. <input type="checkbox"/>	
				From: To:	Sat. <input type="checkbox"/> Tue. <input type="checkbox"/> Fri. <input type="checkbox"/> Sun. <input type="checkbox"/> Wed. <input type="checkbox"/> Mon. <input type="checkbox"/> Thur. <input type="checkbox"/>	

Please identify any food allergies or special needs your child(ren) require:

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Doctor's Name: \_\_\_\_\_

Doctor's Telephone: \_\_\_\_\_

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program as administered in a nondiscriminatory manner.

**\*OPTIONAL\* Participant's ethnic and racial identities** **Please select all that apply**

Name of Enrolled Child(ren)	Age	Foster Child?	Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin sex (including gender identity and sexual orientation), or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

**EMERGENCY CONTACT INFORMATION**

Home Telephone #: \_\_\_\_\_

Work Telephone # \_\_\_\_\_

Parent's Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*\*Form expires one (1) year from this date*

## CACFP MEAL INCOME ELIGIBILITY FORM (Child Care)

Facility Name Kiddie Campus Childcare Center

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<b>PART 1. NAME OF ENROLLED CHILDREN</b>									
<b>*OPTIONAL – Participant’s ethnic and racial data</b>									
<b>Racial and Ethnic data</b> is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State’s compliance with Federal civil rights laws, and your response will not affect consideration of our application, and many be protected by Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.									
NAME OF ENROLLED CHILDREN	AGE	DATE OF BIRTH	FOSTER CHILD?	HISPANIC OR LATINO Yes / No	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
				<input type="checkbox"/> Yes <input type="checkbox"/> No					
				<input type="checkbox"/> Yes <input type="checkbox"/> No					
				<input type="checkbox"/> Yes <input type="checkbox"/> No					
				<input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>ADDITIONAL HOUSEHOLD CHILDREN: _____ TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD: _____</b>									
<b>PART 2. Benefits:</b> If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. <b>If no one receives benefits, skip to PART 3.</b>									
<b>Name</b>			<b>Case Number</b>			<b style="color: red;">NOTE: Case number is not the number found on the EBT card or an individual’s Social Security number</b>			
1. _____			_____						
2. _____			_____						
3. _____			_____						
<b>PART 3.</b> If any child you are applying for is homeless, a migrant, or a runaway, please check the appropriate box and call Your School, Homeless Liaison, or Migrant Coordinator.					<input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway				
<b>PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income</b>									
<b>*Weekly / Every 2 Weeks / Twice A Month / Monthly / Annual *</b>									
Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pension, SSI, VA Benefits, Social Security Retirement	All other income	Check here if No Income				
	\$ _____	\$ _____	\$ _____	\$ _____					
	\$ _____	\$ _____	\$ _____	\$ _____					
	\$ _____	\$ _____	\$ _____	\$ _____					
	\$ _____	\$ _____	\$ _____	\$ _____					

**CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)**

Facility Name Kiddie Campus Childcare Center

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**PART 5. Signatures and Last Four Digits of Social Security Number (Adult must sign)**

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

*I certify that all information on this form is true, and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_

Date: \_\_\_\_\_ (form valid for one (1) year from this date)

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Last four digits of Social Security Number: \* \* \* - \* \* - \_\_\_\_\_  I do not have a Social Security Number  
(required)

**Don't fill out this part. This is for official use only.**

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

Total Income: \_\_\_\_\_  Weekly  Every 2 Weeks  Twice a Month  Monthly  Yearly Household Size: \_\_\_\_\_

Categorical Eligibility: \_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_ Reduced \_\_\_ Denied \_\_\_ Tier I \_\_\_ Tier II \_\_\_

Reason: \_\_\_\_\_

Temporary: Free \_\_\_ Reduced \_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_\_\_ days)

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If applicable, Sponsor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Refer to current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid'.**

HNP Representative Initials/Date  
(for use during CACFP Reviews)

\_\_\_\_\_

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 of 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.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."