Confederated Tribes of Warm Springs of Oregon
Early Childhood Education Center

Dear Parent or Guardian;

Thank you for your interest in **Tribal Daycare Program/Warm Springs Head Start/Early Head Start 2019-20**. Please complete the attached application and return it to the ECE office as soon as possible. ***For your application to be complete; please include the following documentation:***

- Copy of child's birth certificate (or other form of proof of birth)
- Copy of child's Tribal enrollment or verification that child is of Native American descendant.
- Documentation of Disability (if applicable)
- Income Verification or proof of public assistance as claimed on application (check stubs, a letter from employer, previous year's tax return, and documents with public assistance case numbers, etc.)

In addition to the above ***all*** children will need the following health information on file prior to the first day of school or first home visit to be scheduled.

Current Physical Exam or well child check within the past 12 months
(WSHS Physical exam form preferred)
Immunization Records/Immunization Status (must be up to date or have all immunizations possible for their age at time of enrollment)
Dental Exam within last 12 months
(WSHS Oral exam form preferred)
Vision Exam (Head Start Only)
(WSHS Vision exam form preferred)
Blood level lead screening (If age appropriate)
Blood iron level screen (hematocrit or hemoglobin)

Please take time to make appointments as soon as possible. If you are in need of assistance or have questions regarding required health screenings, please call Danni Katchia, Health Coordinator at 553-3242.

Please submit in person completed applications (keep this cover page for reference of documents still needed) **and documentation to the Early Childhood Education office. Our contact information is:**

Tribal Daycare Program
Warm Springs Head Start/Early Head Start
1257 Kot-Num Road
P.O. Box C
Warm Springs, OR 97761
Telephone: (541)553-3242
Fax: (541)553-3379
Email: Jodi.begay@wstribes.org

ECE staff is available to answer questions and assist you as needed to complete your child's application. Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. We look forward to meeting you and your child soon!

Early Childhood Education Center

THIS APPLICATION DOES NOT ENSURE ENROLLMENT. YOU WILL BE NOTIFIED REGARDING THE STATUS OF YOUR APPLICATION AS SOON AS POSSIBLE.

Please mark program desired:

Early Childhood Education Center Application 2019-2020

☐ **Early Head Start** (Prenatal-3 yrs Home based/Year Round
☐ **Head Start** (Age must be 3yrs to 5yrs by Sept. 1): **Full Day (7:45am-3:00pm/Tuesday-Friday)** 10mo (Sept.-June)
☐ **Childcare Program** (6 weeks -3 yrs) Monthly Fee
☐ **Tribal Preschool/Childcare** (3-5yrs) **PM** Monthly Fee (3:00-5:15 & HS Closures)
☐ **School Age Program** (6-9 yrs) Monthly Fee

Please fill out the application completely and accurately. All information is kept confidential. If you have any questions about this application, or need any help in completing it, please call us for assistance we will be glad to help!

☐ Male

Childs Name_____ **DOB**_____ ☐ Female
Last Name Middle First Name

Name of Pregnant Applicant:_____ **Due Date**:_____

Race (check all that apply): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American☐White☐ Native Hawaiian or Other Pacific islander ☐ Other_____ **Ethnicity** (mark one): ☐ Hispanic or Latino Origin ☐ Non-Hispanic or Latino Origin

Tribal Affiliation:_____ **Tribal Enrollment Number:**_____ Descendant? ☐ Yes ☐ No

Primary Language at home: ☐Spanish ☐ English Other:_____

Does child have a documented disability or health impairment? ☐ Yes ☐ No; If yes, what type:_____

Is child receiving services from ESD (Early Intervention)? ☐ Yes ☐ No

Does child have any medical conditions that will require classroom accommodation (ie. food allergies/seizures/asthma)?
☐ Yes ☐ No If yes, please provide more information:_____

Childs Doctor:_____ Childs Dentist:_____
Name Location/Office Name Location/Office

Family Living Address: _____
Street City State Zip

Mailing Address (if different):_____
Street City State Zip

Home Phone:_____ Cell Phone:_____ Message Phone_____

Work:_____ Email_____

Check one: ☐ Two Parent Family ☐ Single Parent Family☐ Foster Family☐ Grandparents ☐ Other_____

Adult 1:_____ DOB:_____ Relationship to child:_____
Last Name Middle First Name

Custody: ☐ Yes ☐ No Lives with family: ☐Yes ☐No Drivers License: ☐Yes ☐ No

Cell #:_____ Work #:_____ Email:_____

Adult 2:_____ DOB:_____ Relationship to child:_____
Last Name Middle First Name

Custody: ☐ Yes ☐ No Lives with family: ☐Yes ☐No Drivers License: ☐Yes ☐ No

Cell #:_____ Work#_____ Email:_____

Is this application for a Foster Child? ☐Yes ☐No Does anyone in your house receive SSI? ☐Yes ☐No

Is your family currently receiving TANF benefits (Cash)? ☐Yes ☐No Do you have permanent housing? ☐ Yes☐ No

If not, please describe your current housing situation: _____

CONFEDERATED TRIBES OF WARM SPRINGS 1855

Early Childhood Education
FAMILY ORIENTATION FORM

We are very happy that you are a part of our Early Childhood Education Program! We want to get to know you better. We want you to know us better. ECE supports families involved in their child's education. To ensure that your child benefits from your involvement please agree to cooperate in the following ways:

This year we will schedule visits in your home, at ECE, or in another place that you choose.

- You will visit with the teachers about your child
- You will visit with your Family Services Staff and Support Services Coordinator to explore:
  - ✓ How you want to be involved in Head Start/Tribal Daycare
  - ✓ What activities interest you
  - ✓ What Community Resources you want to use
  - ✓ Ways to be involved as your child's first and most important teacher
  - ✓ How to enhance your family's economic stability

- There are lots of ways for you to learn about Head Start/Tribal Daycare Program!
  - ✓ Come to a meeting with other families
  - ✓ Talk to a staff person
  - ✓ Come to a family activity
  - ✓ Volunteer in you child's classroom

EARLY CHILDHOOD EDUCATION CENTER POLICIES

CONFIDENTIALITY

- ✓ Your records are held private.
- ✓ Only you and authorized ECE staff will see your child's records.
- ✓ This is a mutual agreement on maintaining transparent and updated information such as; court documentation and income.
- ✓ We will ask for consent before we share your records unless we think your child might be abused. Then we must tell WS Police Department.
- ✓ You have a right to see only your child's Head Start/ECE records.
- ✓ Ask your Family Service Advocate if you want to see the records.

HEALTH

As my child's primary educator/caregiver I agree to submit required health documents before my child's first start date:

- ✓ Up-to-date immunization record
- ✓ Current physical/well-child exam

CHILD ABUSE and NEGLECT

- ✓ All Head Start and ECE staff members are required by law to report suspected child abuse or neglect to Child Protective Services.
- ✓ A report is made when an injury is noticed or if an adult's behavior is harming the child.
- ✓ We work with Child Protective Services and families to keep children safe.
- ✓ The report will be kept confidential, as the law requires.

ATTENDANCE

- ✓ Coming to school every day is important for your child so that she/he can learn.
- ✓ If your child will be absent, call ECE to inform teachers how long they will be absent, please give reasons as to why they are absent.
- ✓ We will call/send message within the school hour if we haven't heard from you.
- ✓ If we cannot reach you, we will try your emergency contact numbers. PLEASE MAKE SURE ECE HAS CURRENT PHONE NUMBERS.
- ✓ If your child has been absent for 3 days in a row, or attendance is irregular, we will call you or make a home visit. We will explore the ways we may help with attendance. Our goal is to ensure that your child is safe and attending Head Start/ECE regularly. Head Start requires 85% or better each month, which means your child, can only miss 3 days a month. (There are exceptions, such as medical, funeral, etc).

SAFE ARRIVAL

- ✓ We want your child to be safe.
- ✓ If your child rides the bus.
    - o Please stay with your child until the bus driver picks them up.
    - o Please be waiting at the bus stop when your child arrives at school.
- ✓ If you bring your child to school please take him or her to his/her classroom and sign him or her in daily. If you do not sign your child in the teacher will do that for you, and you will need to initial at time of pick up.
- ✓ It is important to provide us current court documentation that applies to your child.
- ✓ If I leave my child in someone else's care, I will communicate the responsibilities to the caregiver. I will also inform teacher/caregiver whenever other than myself will be responsible for my child.
- ✓ I understand that my child must be picked up by ECE before 3:00pm (Head Start) or 5:15pm (Daycare)

DIVERSITY/INCLUSIVITY

- ✓ We always want to include everyone,
- ✓ We will plan activities so all children and families can join in.
- ✓ We respect everyone's values and beliefs.
- ✓ We plan around the summer, fall, spring and winter seasons.
- ✓ We plan activities that focus on light, weather, sharing, clothing, families and other common concepts like these.
- ✓ We help families in their own celebrations by sharing information about community resources and events.
- ✓ We learn from children as they share stories about family or religious celebrations.

TOBACCO/DRUG-FREE ENVIRONMENT

- ✓ No drugs or tobacco products are allowed at ECE.
- ✓ No smoking within 25 feet of building.

SAFETY RULES

- ✓ Paid staff must stay with children at all times—on playground, in bathrooms, on field trips and in the classroom.
- ✓ Only paid staff can let visitors into the classroom or playground.
- ✓ I understand that transportation for my child to and from the Center is my responsibility.
- ✓ I will complete an emergency contact with 4 contacts other than myself. I understand that it is my responsibility to update my child's contacts, as needed.
- ✓ We will let your child go only with the people you have listed on the "Emergency Contact Form". All visitors will be stopped at Front Desk, they need to sign in and get a visitors pass.
- ✓ Remember: always put on gloves before helping someone who is sick or hurt. Keep other's blood, vomit, urine, and feces away from your skin.
- ✓ I will see that my child has medical attention when necessary, I understand that is my child is sick or excluded, I must pick them up within one hour of being notified. My child must be readmitted through the Health Coordinator before returning to class.
- ✓ I will read posted information, flyers, newsletters that are available throughout ECE.

STAFF/VOLUNTEER BEHAVIOR WITH CHILDREN

- ✓ ECE wants all children to be safe.
- ✓ All staff and volunteers will be trained about good ways to work with children.
- ✓ Ask staff if you have any questions about what is okay to do or say.
- ✓ The law states that any staff or volunteer who hurts a child must be reported to CPS or the police. This includes causing <u>physical pain</u> (hitting, pinching, spanking, kicking, pulling hair or arms), <u>emotional pain</u> (yelling, calling bad names, scaring children) or <u>sexual acts</u> (touching a child's private body, showing your private body, etc.)
- ✓ If you are a volunteer, you cannot be left alone with a group of children or a child other than your own.
- ✓ If a volunteer does something that may be hurtful, a staff person may talk with the volunteer. Staff may decide to ask the volunteer to stop volunteering.
- ✓ If a staff person does something that may be harmful, the ECE Administrator or Supervising Coordinator will talk with the worker about their words and actions. The worker may be told not to come to work while the Administrator tries to find out what happened. The Administrator will decide if the worker can return to work or be fired.
- ✓ Volunteers who work with children a lot will need to have a: (**1**) Criminal background check (to see if you have a record of any crimes or actions that hurt children) and (**2**) you may need to have a Tuberculosis (**TB**) test. Head Start can pay any costs.

COMMUNITY COMPLAINTS

- ✓ I understand that I have the right to bring any of my concerns or suggestions to the attention of my child's teachers or program supervisor.
- ✓ You have the right to make a complaint if you are unhappy with something that is happening to you or your child in ECE.
- ✓ If your concern is about a staff person, talk first with him or her to try and address the issue.
- ✓ If talking directly doesn't work, write down your concern and send it to the Administrator.
- ✓ If the problem remains, your complaint will be referred higher up. If needed, our Tribal Council Liaison and Head Start Policy Council Chair will conduct an investigation.

Parent/Guardian Signature: Date:

ECE Staff Signature: Date:

EARLY CHILDHOOD EDUCATION CENTER

1257 Kot Num Road ~ P.O Box C ~ Warm Springs, OR 97761 ~ 541-553-3242

Medical Consent & Release of Medical Information Form

Child's Name: _____ D.O.B:____/____/____ Classroom/Home Visitor: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Emergency medical care will be provided to ALL persons brought to the Warm Springs Health and Wellness Center (Indian Health Service) but non-beneficiaries are ordinarily expected to obtain medical and dental care from private providers. If NON-I.H.S. eligible, please specify provider:

_____

Warm Springs Head Start will make every effort to contact you or your emergency contact prior to taking any actions.

I have legal responsibility for the above child and hereby give consent for the Warm Springs Health and Wellness Center (Indian Health Services) and Warm Springs Head Start staff to arrange for/or provide the following health services while attending the Warm Springs Head Start Program:

A MARK IN THE BOX INDICATES APPROVAL:

- ☐ Emergency medical care for accidents or illness
- ☐ Administer first aid and/or CPR, if necessary
- ☐ Appropriate response to any local outbreak of contagious illness
- ☐ To conduct vision, dental, hearing and developmental screenings
- ☐ I give permission to I.H.S. medical staff or Public Health Nurse to examine my child while at the Early childhood Education Center
- ☐ I give WS Head Start permission to transport my child to and from the health facility for services
- ☐ I Consent to the release of immunization records to the Warm Springs Head Start Program
- ☐ I agree to sign the appropriate release of information forms so my child's medical, dental, nutritional and developmental records can be utilized for program planning and review. The records will remain confidential.
- ☐ I give permission for my child to be observed in the classroom by the HS/EHS Disability Coordinator and licensed behavioral health team member.

_____

Parent/Guardian Signature Date

Turn over Complete Backside

WARM SPRINGS EARLY CHILDHOOD EDUCATION HEALTH HISTORY

Name of Child: _____ **Date of Birth:** _____

Signature of Parent/Guardian Completing Form: _____ **Date:** _____

Date of last well child exam: _____
Name of doctor or clinic: _____
Does child have a dentist? Yes No Was child premature? Yes No
Does child currently take any medication? Yes No How many weeks? _____
If yes, what type? _____ **How often?** _____

Has the child had any of the following conditions?

Condition:	YES	NO	Condition:	YES	NO
Allergies			Whooping Cough		
Asthma			Scarlet Fever		
Anemia			Rheumatic Fever		
Serious Accident			Chicken Pox		
Serious Illness			Hepatitis A		
Surgery or Hospitalization			Hepatitis B		
Diabetes			Rotavirus		
Heart Disease			Jaundice		
Liver Disease			Frequent Cough		
Hemophilia			Frequent Sore Throat		
Sickle Cell Disease			Stomach Pain		
Epilepsy			Diarrhea/Vomiting		
Seizures			Eczema or Skin Problems		
Tuberculosis			Impetigo		
Polio			Hearing Problems		
Measles			Vision Problems		
German Measles			Lactose Intolerance		
Mumps			Traumatic Brain Injury		
Meningitis			Autism		
			Other:		

Please explain any "yes" answers above: _____

DEVELOPMENTAL DISABILITY	YES	NO
Does your child have any suspected developmental delays?		
Does child require special equipment or accommodations?		

Please provide brief explanation of suspected developmental delay: _____

Please provide description of braces or equipment: _____

SMOKE EXPOSURE	YES	NO
Is your child exposed to second hand smoke?		
Is tobacco currently in use in your home? i.e. smokeless tobacco (chew), cigars, pipes, cigarettes or e-cigarettes?		

Please give explanation of any "yes" answer: _____

I give my consent for Warm Springs Head Start/EHS to perform the following services for my child, while my child is enrolled in Head Start/EHS (Please Initial):

____ Transportation to/from the Head Start site, when available

____ Informal classroom observation by Head Start and High Desert ESD staff to provide technical assistance to teachers

____ I give permission for my child to be observed in the classroom by the HS/EHS Disability Coordinator and licensed behavioral health team member.

____ Developmental screenings, assessments, and ASQ-3/ASQ-SE

____ Health screenings (Dental, Vision, Height & Weight and Hearing)

____ Photograph or videotape for Head Start staff training and Planning

____ Photograph or videotape for promotion of Head Start with community partners

____ State Child Profile Immunization record

Parent/Legal Guardian Signature Date

EMERGENCY CONTACT INFORMATION

Warm Springs Early Childhood Education

Child's Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Room: _____ Teacher Name(s): _____

Please give the names and telephone numbers of four persons (neighbors, friends and relatives), plus yourself, that we can call during the day to assume responsibility for your child in your absence (i.e. emergency, left at school, etc.)

Authorized people must be at least 14 years old and have a telephone number where they can be reached during the day and live locally. (Close to the ECE Center) and must agree to be an emergency contact for your child.

PARENT/LEGAL GUARDIANS

Name:_____
Street/Home:_____
Home Phone:_____
Workplace:_____
Work Phone:_____
Pager/Cell/Message:_____

Name:_____
Street/Home:_____
Home Phone:_____
Workplace:_____
Work Phone:_____
Pager/Cell/Message:_____

CONTACTS

Name:_____
Street/Home:_____
Home Phone:_____
Workplace:_____
Work Phone:_____
Pager/Cell/Message:_____

Name:_____
Street/Home:_____
Home Phone:_____
Workplace:_____
Work Phone:_____
Pager/Cell/Message:_____

Name:_____
Street/Home:_____
Home Phone:_____
Workplace:_____
Work Phone:_____
Pager/Cell/Message:_____

Name:_____
Street/Home:_____
Home Phone:_____
Workplace:_____
Work Phone:_____
Pager/Cell/Message:_____

PERSONS WHOM I AUTHORIZE TO ASSUME RESPONSIBILITY FOR MY CHILD

Child's Name: _____ Classroom:_____

PLEASE PROVIDE THE FOLLOWING INFORMATION TO LET US KNOW WHO MAY PICK UP & SIGN OUT YOUR CHILD

Parent/Guardian:_____
1)_____
2)_____
3)_____

Parent/Guardian:_____
4)_____
5)_____
6)_____

If someone, other than these people will be signing your child out, please let your child's teachers know prior to sign out time.

☺_____ _____

Parent/Legal Guardian Signature Date

white copy - classroom, yellow copy - front desk, pink copy - child file

Early Childhood Education Center

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

To our families: The Early Childhood Education Center works together with other agencies that know you and your family. By signing this form, you are giving permission for our program and the specified agencies to share relevant information in order to more effectively serve your family.

STUDENT INFORMATION

Child's Name: _____ **Date of Birth:** ___/___/___

School: _____ **Grade:** _____

PARENT INFORMATION

Parent/Guardian: _____ **Date of Birth:** ___/___/___

Parent/ Guardian: _____ **Date of Birth:** ___/___/___

I _____ authorize the exchange of information described below between Warm Springs Head Start/Early Head Start and the Tribal Day Care Program the following agency(s) and/or individual(s) **PLEASE INITIAL**:

_____ Tribal Day Care Program

_____ Services to Children & Families

_____ Adult & Family Services

_____ Children's Protective Services

_____ Early Childhood Education

_____ CTWS Public Health

_____ Mental Health Program

_____ 509-J School District

_____ Teen Parent Program

_____ Indian Health Services

_____ Early Intervention/ Early Childhood Special Education

_____ WS Community Counseling Center

____ WIC

____ Mt. View Hospital

____ St. Charles Medical Center

____ Other (specify): _____

I understand that these records will be treated as confidential by the Head Start/Early Head Start Program. A copy of this form is valid to give permission to disclose records.

_____

Parent/Guardian Signature **Date**

This ROI is good for one year. Expiration Date: _____

Renewal Date: _____ **Parent Initials:** _____

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at a child care center. **Warm Springs Early Childhood Education Center** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Confidential Income Statement. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Confidential Income Statement for each of my children in day care?** Complete and submit one CACFP Confidential Income Statement for all children in your household **only** if they are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: Danni Katchia, Warm Springs ECE; P.O. Box C; Warm Springs, OR 97761.**

2. **Who is eligible for free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) are eligible for free meals. Foster children and children enrolled in Head Start based on income are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. **Who can get reduced price meals?** Your children can get low-cost meals if your household income is within the reduced price limits on the Federal Income Guidelines shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the center or the day care home.

5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Federal Income Guidelines, the family day care home or center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility guidelines.

7. **What if my income is not always the same?** List the amount that you normally earn. For example, if you normally earn $1000 each month, but you missed some work last month and only earned $900, put down that you earn $1000 per month. If you normally earn overtime, include it, but not if you only earn it sometimes.

8. **What if I have foster child(ren)?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the confidential Income Statement, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **Danni Katchia, Warm Springs ECE; P.O. Box C; Warm Springs, OR 97761.**

9. **We are in the military; do we include our housing and supplemental allowances as income?** If 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.

10. **Centers charging for meals only (Pricing programs only). Will the information I provide be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your sponsoring organization. You may ask for a hearing by calling or writing to: **Danni Katchia, Warm Springs ECE; P.O. Box C; Warm Springs, OR 97761.**

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **541-553-3242.**

Sincerely,

Danni R Katchia

This institution is an equal opportunity provider.

OMER Roster Number _____

2019-2020 CONFIDENTIAL INCOME STATEMENT – Child Care Centers/Family Day Care Providers

INSTRUCTIONS:

- If your household received SNAP, TANF or FDPIR, complete parts 1-3, and 5; part 6 is optional.
- If you do not receive these benefits and your income is below the guidelines (back) complete parts 1, 2, 4, and 5; part 6 is optional.
- If you are applying for a FOSTER CHILD only, complete parts 1, 2, and 5; part 6 is optional.

Any income fields left blank will be counted as zeros. Please be careful that you meant to leave income fields blank.

HOUSEHOLD INFORMATION

Print name of person completing this application (Last name, First name)

Name **Print**

Mailing Address – Apt #

City State Zip

Home Phone or Cell Phone (Circle One)

Work Phone

➔ Number living in this household _____
(Write names of **all** household members on part 2 and/or part 4 of this form)

CHILD INFORMATION – (Names of Your Children *Enrolled* in Child Care)

Child's Name (Legal Last name, First name)	Birth Date	Age	Check if Foster Child (placed by welfare agency or court) If only foster care child(ren) see instructions above
1.			☐
2.			☐
3.			☐

PUBLIC BENEFITS Indicate which **benefits** your household currently receives, and list case number, if any:

Name: _____ Case Number: _____

- ☐ SNAP (Supplemental Nutrition Assistance Program) *(Oregon Trail Card number not acceptable)*
- ☐ TANF (Temporary Assistance to Needy Families) *(Employment Related Day Care does not qualify)*
- ☐ FDPIR (Food Distribution on Indian Reservations)

HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

	Column 1 List **all** household members, including children not attending school, and income. Do not include children listed in part 2, unless they receive regular income. *(Last name, first name)*	**Column 2** MONTHLY INCOME (Total earnings & wages before deductions)	**Column 3** MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED	**Column 4** MONTHLY PENSIONS, SOCIAL SEC., RETIREMENT, SSI, VA	**Column 5** OTHER MONTHLY INCOME -Including unemployment and workers comp.	**Column 6** Check if No Income
1.						☐
2.						☐
3.						☐
4.						☐
5.						☐
6.						☐
7.						☐

SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

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.

Signature of Adult Household Member

X _____

Date Signed

_____
Month/day/year

Social Security Number
(See privacy statement on back)

XXX-XX - _____

☐ **I do not have a Social Security Number.**

RACIAL OR ETHNIC GROUP (OPTIONAL)

Mark one ethnic identity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ Asian
- ☐ American Indian & Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other

SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income:_____ Number in Household:_____

Centers

Eligibility : ☐Free ☐Reduced Price ☐Above Scale

Eligibility based on : ☐SNAP ☐TANF ☐ FDPIR ☐Household Income ☐ Foster Child

FDCH

☐Tier 1 ☐Tier 2

Notes: _____

Determining Official's Signature :_____ Date_____

Second Check Signature: _____ Date_____

OMER Roster Number ________

Child and Adult Care Food Program CHILD ENROLLMENT FORM

Child Care Centers/Head Start Programs

____

CACFP Sponsor Name/Site Name

TO BE COMPLETED BY PARENT/GUARDIAN ONLY

The CACFP reimburses centers for serving nutritious, well-balanced meals and snacks to children in care.
Complete the following chart for all children in care. Sign, date, and return to the center. Use additional forms, as needed.
Parents/guardians of all infants must complete the Infant Formula Selection section.

Children's Names	Normal Hours in Care: Enter the **time** your child usually *arrives* each day.	Normal Hours in Care: Enter the **time** your child usually *leaves* each day.	Normal Meals and Normal Days in Care
Last:	______ Time	______ Time	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	☐ AM ☐ PM	☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last	______ Time	______ Time	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	☐ AM ☐ PM	☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last	______ Time	______ Time	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	☐ AM ☐ PM	☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last	______ Time	______ Time	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	☐ AM ☐ PM	☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

Parent/Guardian Print Name: ______________________________ Date____________

Parent/Guardian Signature: ______________________________

INFANT FORMULA SELECTION: Complete if any child listed above is an infant under one year of age

This center provides ______________________ (list brand) iron fortified infant formula.

Check one:
☐ I accept the center provided formula
☐ I decline the center provided formula
I understand that by declining the center provided formula, I agree to provide breast milk or formula for my child. If I provide formula it must be on the approved formula list for the center to be reimbursed for the meal.

Updates: *(annual at a minimum)*	The parent/guardian signing this form certifies that the enrollment information is correct. If information has changed, the parent/guardian has written the appropriate changes on the form and initialed the change. *If there are many changes, please complete a new form.*	
First Update	*Parent/Guardian Signature*	*Date*
Second Update	*Parent/Guardian Signature*	*Date*
Third Update	*Parent/Guardian Signature*	*Date*
Fourth Update	*Parent/Guardian Signature*	*Date*

This institution is an equal opportunity provider.