Community Art Center, Inc.
119 Windsor Street
Cambridge, MA 02139
617-868-7100
www.communityartcenter.org

VOUCHER
INITIAL INTAKE CHECKLIST

Parent's Name:_____ **Child's Name:**_____

CAC Staff:_____ **Date of Intake:**_____

Community Art Center Forms:

- ☐ CAC Application Form
- ☐ Child Profile Form
- ☐ Family Demographic Form
- ☐ Medication Consent Form
- ☐ First Aid and Emergency Medical Care Consent Form
- ☐ Parent Contact Information Form
- ☐ CACFP Form
- ☐ CAC Policy Agreement Form
- ☐ Photo ID for Parents
- ☐ Social Security Cards for parent and child/ren
- ☐ Birth Certificate for Child/ren
- ☐ Annual Physical and Updated Immunization Records

Fee:

- ☐ Voucher
- ☐ Billing Policy and Fee Agreement

_____ _____
Signature of Director of Operations and Finance Date

_____ _____
Signature of School Age Child Care Program Manager Date

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SCHOOL AGE CHILD CARE INFORMATION FORM

CHILD'S NAME:			DATE:		
ADDRESS:			PRIMARY LANGUAGE:		
CITY:			SCHOOL:		
STATE:			HOME TEL#		
ZIP:			DATE OF BIRTH		
IS THIS THE MAILING ADDRESS?	YES	NO	GENDER:	MALE	FEMALE

PARENT INFORMATION

PARENT/GUARDIAN #1		EMAIL:	
HOME ADDRESS:		CELL PHONE #	
OCCUPATION:		WORK HOURS:	to
BUSINESS NAME:		WORK PHONE#	
ADDRESS:		CITY:	ZIP:
PARENT/GUARDIAN #2		*PHONE #*	

EMERGENCY INFORMATION

1. Name of emergency contact OTHER than parent:			
RELATIONSHIP to child:	PHONE#		
2. Name of emergency contact OTHER than parent:			
RELATIONSHIP to child:	PHONE#		

IS YOUR CHILD ALLERGIC TO ANYTHING ? (circle)	**YES**	**NO**
IF YES WHAT IS YOUR CHILD ALLERGIC TO?		
DOES YOUR CHILD HAVE A PERSCRIPTION FOR THEIR ALLERGY?	**YES**	**NO**
IF YES PLEASE PROVIDE PERSCRIPTION IN ORIGINAL PACKAGING & DIRECTIONS		
ANY OTHER MEDICAL CONDITIONS?	**YES**	**NO**
IF YES, PLEASE EXPLAIN:		

Is there documentation of a physical exam, immunization record and lead screening on file at your child's school? (circle)	**YES**	**NO**
Does your child have permission to play sports? (circle)	**YES**	**NO**

WHAT IS YOUR CHILD'S DENTIST NAME ?			
ADDRESS:		TELEPHONE #	
HEALTH CARE PROVIDER:	POLICY #		
CHILD'S IDENTIFYING INFORMATION:		WEIGHT:	HEIGHT:
BIRTH MARK:	HAIR COLOR:	EYE COLOR:	SKIN:

I understand that the staff at the Community Art Center is trained in the basics of first aid and I authorize them to administer first aid to my child if needed. *I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I can not be reached, I hereby authorize the staff on duty to transport my child to the nearest medical care facility and secure medical treatment necessary including, but not limited to hospitalization, injections, anesthesia, or minor surgery.*

Parent or guardian signature Date

CONSENT TO RELEASE

I give my consent to the Community Art Center to release my child to the following persons, in addition to me, the parent/guardian. The following are authorized to take my child from the program.

NAME:	RELATIONSHIP TO CHILD:
STREET ADDRESS:	CITY: ZIP:
TELEPHONE#	WORK PHONE#
NAME:	RELATIONSHIP TO CHILD:
STREET ADDRESS:	CITY: ZIP:
TELEPHONE#	WORK PHONE#
NAME:	RELATIONSHIP TO CHILD:
STREET ADDRESS:	CITY: ZIP:
TELEPHONE#	WORK PHONE#

OFF-SITE CONSENT TRANSPORTATION & PICK UP AUTHORIZATION

I understand the Community Art Center/SACC program will use it's van whenever possible, but does not guarantee transportation. If the children participate in field trips they may be required to use public transportation or bus companies. I give my child permission to participate in all of the regularly scheduled on-going activities at the following off-site facilities:

Neighborhood parks, the library, nearby schools and other community events.

I understand the staff has the right to restrict the above privilages if my child's behavior warrants limitation of is she/he does not honor the code of discipline. I understand that the staff will not accompany my child during an unsupervised walk to and from the program. I understand I am responsible for my child once she/he leaves the program.

I give my child permission to leave at her/his own choice.			**CALL**	**YES**	**NO**
MY CHILD WILL ARRIVE BY:	____	CAC Supervised walk	____	UNSUPERVISED WALK	
Please check one	____	PARENT DROP OFF	____	SCHOOL BUS	CAC VAN
MY CHILD WILL LEAVE BY:	____	*CAC Van*	____	*UNSUPERVISED WALK*	
Please check one	____	PARENT PICK UP		*for ages 9 and up*	

VOLUNTEER INFORMATION

ARE YOU WILLING TO VOLUNTEER YOUR TALENTS OR TIME?	YES	NO

_____	PARENT COUNCIL	_____	SPECIAL EVENTS
_____	TEACHER AIDE	_____	ADMINISTRATIVE HELP

PAYMENTS & POLICIES

I understand that the semi-monthly fee is due on the 1st and 15th of every month, unless other arrangements have been made with the Administrative Coordinator. I understand the fee is tuition based and I may not deduct in the event of my child's absence for sickness, vacation, severe weather conditions or suspensions. I have received a Parent Handbook and have reviewed your policies. I understand them to the best of my abilities. **Note:** if you choose to terminate, you are required to give CAC a two (2) week notice. If not, you will be responsible for the two (2) week billing period after your child(ren) has left the program.

Parent or guardian signature _____ Date _____

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CHILD'S PROFILE

Child's Name_____**Gender**_____**Age**_____**Grade**_____.

The information provided on these pages will assist our staff in providing a positive experience for your child.

1. At home my child usually plays:
   a. With a large group of friends
   b. With a small group of friends
   c. Alone
   d. With older children
   e. With younger children

2. When my child gets angry he/she:
   a. Sulks/Cries
   b. Fights
   c. Throws things
   d. Wants to get back at someone
   e. Bites
   f. Spits
   g. Soils his/her clothes
   h. Shuts down/will not speak

3. My child is most interested in:
   a. Media Art
   b. Visual Art
   c. Music
   d. Theatre
   e. Dance
   f. Nature/ Sports

4. My child is:
   a. Happy to go to the Community Art Center
   b. A little apprehensive about the CAC
   c. Has been to the CAC before
   d. Has never been to CAC

5. My child:
   a. Has an IEP
   b. Seeks counseling or therapy Takes medicine on a regular basis
   c. Would benefit from receiving counseling
   d. Could use behavioral support in the program
   e. Has been given a diagnoses in the last three years:
   f. _____
      _____

6. Please indicate with a check your child's current general disposition and behaviors that most frequently occur:
   ___Quiet ___Affectionate
   ___Active ___Easily frustrated
   ___Irritable ___Frequently cries
   ___Happy ___ Tantrums
   ___Curious ___ Withdrawn
   ___Has difficulty with siblings
   ___Makes friends easily
   ___Seeks constant attention

7. I usually discipline my child by:_____
   _____
   _____

8. One specific goal/hope I would like my child to accomplish this year is:_____
   _____
   _____

9. Is there any additional information that you feel would be helpful to the staff:_____
   _____
   _____

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FAMILY DEMOGRAPHIC INFORMATION

☐ **EEC** ☐ **VOUCHER** ☐ **PRIVATE**

STUDENT LAST NAME	STUDENT FIRST NAME	MI	GENDER Male Female
STREET ADDRESS	CITY	SATE	ZIP CODE
TELEPHONE NUMBER	SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH

	FAMILY SIZE		***FAMILY INCOME***
	Household size including you		
	1. PERSON		$100,001+
	2. PERSONS		$78,001 - $100,000
	3. PERSONS		$73,001 - $78,000
	4. PERSONS		$68,001 - $73,000
	5. PERSONS		$63,001 - $68,000
	6. PERSONS		$58,000 - $63,000
	7. PERSONS		$53,000 - $58,000
	8. PERSONS		$0 - $53,000

	SOURCE OF INCOME						
	Check all that apply						
	BPS FR. LNCH PROGRAM		SSI/SSDI		FOOD STAMPS		REFUGEE ASSITANCE
	EMPLOYMENT		CHILD SUPPORT		ALIMONY		AFDC
	UNEMPLOYMENT		TAFDC RECIPIENT		OTHER		MEDICARE

	NEIGHBORHOOD						
	Check area you live						
	CAMBRIDGE		EAST CAMBRIDGE		MEDFORD		MALDEN
	AREA IV, CAMBRIDGE		SOMERVILLE		JAMAICA PLAIN		

	ETHNICITY/RACE						
	OTHER		WHITE non Latino		BLACK non Latino		LATINO
	AMERICAN INDIAN		ALASKIN NATIVE		AFRICAN		PACIFIC ISLANDER
	HAITIAN		CAPE VERDEAN		AFR. AMERICAN		ASIAN

	CHARACTERISTICS						
	Check all that apply						
	OTHER		VETERAN STATUS		PUBLIC HOUSING		SPECIAL NEEDS
	REFUGEE		FEMALE-HEADED HOUSEHOLD		PHYSICAL DISABILITY		MALE-HEADED HOUSEHOLD

I hereby confirm that the information that I have provided on this form is true and accurate to the best of my knowledge.

Parent/Guardian Signature _____ Date _____

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)**_____

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____**, (parent or guardian) gives permission**
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)
Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent /Guardian Signature Date (valid for one year)

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
PARENT CONTACT INFORMATION FORM

The Department of Early Education and Care (EEC) requires that families maintain updated contact information, which includes: physical address, mailing address, phone number(s), and e-mail addresses. If your contact information changes during your Authorization period, you must submit a copy of this form to your Subsidy Administrator. These changes are expected to be reported immediately, but no later than 30 days from the date of the change. **All correspondence will be sent to the address on file. If we do not have a current and accurate address, it may impact our ability to reach you with important notices in a timely manner.** Documentation of the change (such as proof of address) does not need to be submitted until your next Reauthorization. Please complete the entire form.

Please check appropriate box:

☐ **Initial** ☐ **Change/Update**

Physical Address: _____

_____

Mailing Address: _____

_____

Home Number: _____

Work Number: _____

Mobile Number: _____

E-Mail Address: _____

EEC encourages the use of technology to notify Parents of any changes to your subsidy or to advise that it is time to have your subsidy Reauthorized. Please indicate below if you are requesting to receive your notifications via e-mail.

Notifications via e-mail is offered by this Subsidy Administrator: ☐ Yes ☐ No

☐ Yes, I would like to receive notifications via e-mail

☐ No, I would like to receive notifications via U.S. mail

Signature of Parent: _____ Date: _____

Print Parent Name: _____

Subsidy Administrator Agency Name: _____

Subsidy Administrator Staff Member: _____

Received on: _____
DATE

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Community Art 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 Meal Benefit Income Eligibility Form. 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 Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care 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: Community Art Center, 119 Windsor Street, Cambridge MA 02139, 617-868-7100**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) or Temporary Assistance for Families of Dependent Children (TAFDC), benefits can get free meals. Foster children and children enrolled in Head Start 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 Chart, 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 child care center.

5. Who should I include as members of my household? You must include everyone 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 Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

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

8. What if I have foster children? 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 Meal Benefit Form, but are not required to include payments received for the foster child as income.

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.

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 **617-868-7100**.

Sincerely,

Community Art Center

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

INSTRUCTIONS FOR COMPLETING THE CACFP
MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

If any member of the household gets SNAP or TAFDC, follow these instructions:

Part 1: List all enrolled children and household members. For any person, including children, with no income, you must check the "No Income Box".
Part 2: List the case number for any household member receiving SNAP or TAFDC benefits.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.
Part 4: Skip this part
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:
Part 1: List all foster children**.** Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose to.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.
Part 4: Follow these instructions to report total household income for this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Report income after expenses in Box 1 only if self employed. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call your Child Care Sponsor for further instructions. If not, skip this part.

Part 4: Follow these instructions to report total household income form this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your paystub or your boss can tell you.
Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. Report income after expenses in Box 1 only if self employed. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

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

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received SNAP or TAFDC cash assistance, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the Child Care Sponsor at Phone #: Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often

	B. Gross income and how often it was received			
A. Name (List **only** household members with income)	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 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 Privacy Act 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: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

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: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Eligibility: Free___ Reduced___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Effective July 1, 2020 to June 30, 2021	
Household size	**Yearly**
1	23,606
2	31,894
3	40,182
4	48,470
5	56,758
6	65,046
7	73,334
8	81,622
Each additional person:	+8,288

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.

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: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

SHARING INFORMATION WITH MEDICAID/CHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get low to no cost health insurance through Medicaid or the Children's Health Insurance Program (CHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and CHIP that your children are eligible for free or reduced price meals, *unless you tell us not to***. Medicaid and CHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or CHIP, fill out the form below and send it with your Income Eligibility Form to **[address] by [date]**. (Sending in this form will not change whether your children get free or reduced price meals.).

❑ **No! I DO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

_____

For more information, you may call **Jada Alleyne** at **617-868-7100 ext. 125**