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

INCOME ELIGIBLE INITIAL INTAKE CHECKLIST

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

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:

- ❑ Parent Fee Agreement

_____

Signature of School Age Child Care Program Manager

EEC Assessment Forms:

- ❑ Financial Assistance Agreement form signed by parent
- ❑ Attendance Notification form signed by parent
- ❑ Household Composition Form
- ❑ Household Income Statement
- ❑ Employment Verification Form
- ❑ Address Verification (custodial and non-custodial parents if applicable)
- ❑ Child Support Info Form Signed by Parent

Income Documentation:

- ❑ 4 consecutive weeks pay stubs
- ❑ Letter from employer (indicates hours and rate)
- ❑ Verification of Parental Incapacity Form (if applicable)
- ❑ Verification of Special Need of Child Form (if applicable)

Reassessment Date _____

_____

Signature of Director of Operations and Finance

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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**

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
FINANCIAL ASSISTANCE AGREEMENT

This document explains your rights and your obligations regarding EEC child care financial assistance. Please read this document carefully and ask for clarification if you do not understand any part of it. You should keep a copy for your files.

Parent's Initials:

_____ I understand that it is unlawful to obtain EEC financial assistance for child care services by providing false or misleading information or documentation, or the concealing or withholding of information ("Substantiated Fraud"), for the purpose of establishing or maintaining eligibility or increasing the level of child care assistance. Substantiated Fraud may result in the termination of my child care financial assistance. Some examples of such unlawful behavior include, but are not limited to:

- Not reporting who is in my household (for example, not reporting that I am married or the child's other parent lives with me);
- Not reporting all sources of my income (for example, not reporting that I receive income from another source such as: employment, rental income, child support, alimony, or financial help from another parent to assist with my child's basic needs);
- Not accurately reporting how much income I receive (for example, not reporting all money received from self-employment, or altering or falsifying pay stubs);
- Not accurately reporting service need or changes to service need for all parents (a service need is the activity - work, education, or training - performed during the time you need child care).

_____ I understand that if I receive EEC financial assistance as a result of false or misleading information or documentation, or as a result of the concealing or withholding of information ("Substantiated Fraud"), I shall be responsible for repayment of the full amount of subsidy obtained through fraud and may be held criminally responsible.

_____ **I understand that I must report Temporary and Non-Temporary Changes within thirty (30) days from the date the change occurred.** Temporary Changes include: time limited absence from a service need due to illness or need to care for a family member (including maternity/paternity leave), interruption in work for a seasonal worker, reduction in service need hours, any ending of a Parent's approved activity due to the COVID-19 emergency, change or ending of a parent's service need that lasts less than 12 weeks, and a change of residency within the Commonwealth. Non-temporary Changes include**:** increases in total household income exceeding 85% of State Median Income (SMI); changes in family contact information; changes in household composition; changes in child custody arrangements; any out of state change in address; or any change or ending of a parent's service need that lasts more than 12 weeks. I understand that failure to report Non-Temporary Changes will result in an Intentional Program Violation (IPV) and may make me subject to disqualification from EEC financial assistance

_____ I understand that to verify my income and service need, EEC or the Subsidy Administrator may need to contact my employer(s), college/university, school, or training program. I hereby authorize my employer(s) or school administration to release information about my income, pay, hours, schedule of work, and school enrollment information to EEC or the Subsidy Administrator to whom I apply for subsidized child care services.

_____ I understand that if my child(ren) are not actively enrolled in care for more than 60 days (unless I have an Approved Break in Care) my subsidy may be terminated for Abandonment of Subsidy. I understand that if I have a School Closure Only voucher that I must use care for at least four (4) days during my child's academic year or risk termination for Abandonment of Subsidy.

_____ I understand that my child may be terminated for Excessive Unexplained Absences. This is failure to attend the subsidized child care program for more than three consecutive Days without contacting the provider. I understand that I must contact my provider every Day that my child(ren) will not attend.

_____ I acknowledge that if I have a voucher, the Child Care Resource & Referral Agency (CCRR) has explained to me EECs health and safety requirements for licensed early education and care providers, including center-based programs and family child care homes. I understand that certain programs are not subject to all of EEC's health and safety regulations. I have made an informed choice of the early education and care provider named on the Application and Fee Agreement and agree to hold the Commonwealth, the early education and care program and the CCRR harmless from any injury or neglect to my child(ren) which results while in the care of the child care provider.

I certify under the pains and penalties of perjury that the information provided is correct and complete to the best of my knowledge.

Parent Name_____ SSN _____

Address _____

Parent Signature_____ Date _____

Subsidy Administrator Staff Member Name _____Subsidy Administrator Agency Name _____

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
ATTENDANCE NOTIFICATION AGREEMENT

Your child(ren) are receiving an EEC child care subsidy and are expected to attend the early education and care program, in accordance with the terms of your child care authorization. Child care educators/providers are responsible to ensure that your child(ren) attend in accordance with terms of your child care authorization.

EEC defines Excessive Absences as more than 45 non-attended days, including any unexplained absences, within a 12 month Authorization period, or more than 15 non-attended days during an initial 12 week Provisional Authorization period. Parent(s) will be financially responsible for all non-attended days over the 45 day limit during a 12 month authorization or all non-attended days over the 15 day limit during a 12 week Provisional Authorization.

To avoid having to pay for Excessive Absences you must:

1. Ensure that your child(ren) attend(s) the early education and care program, in accordance with the terms of your child care authorization;

2. Notify your Subsidy Administrator of a recurring change in your child(ren)'s schedule of care (i.e. after school programs, sports, custody arrangements) which will result in your child(ren) not needing child care on a particular day or days of the week;

3. Contact your provider whenever your child(ren) will not attend; and

4. Provide at least 2 weeks advance written notice if you plan to remove your child(ren) from the child care program or wish to request an Approved Break in Care.

You will be issued notifications from your Subsidy Administrator after your child(ren) have reached non-attended day 30 and non-attended day 40. If you have a 12-week provisional authorization, you will be notified after your child(ren) have reached non-attended day 10. The purpose of these notifications are to inform you when your child(ren) are approaching the Excessive Absence limit so that you can be aware of the impact of future non-attended days.

After your child(ren) have reached the 45th non-attended day, or the 15th non-attended day during a 12-week provisional authorization period, you will be notified that your child(ren) have reached the Excessive Absence limit and that you are now responsible for the payment of all additional non-attended days during the authorization period at the full rate that EEC pays for your child care. You will be asked to sign the Excessive Absence Warning Notice form acknowledging that you are willing to remain in care and will be responsible for the payment of all non-attended days during the remainder of the authorization period. Please note that failure to sign the form **will not** excuse you from paying for additional non-attended days. **Failure to pay for additional non-attended days may result in the termination of your subsidized child care.**

My signature below indicates that I understand the information in this document and agree to comply with the requirements above.

_____ _____

Printed Name of Parent Date

_____

Signature of Parent

Effective Date: March 1, 2019

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
HOUSEHOLD COMPOSITION STATEMENT

Please read carefully and mark "X" to all that apply.

I certify under penalty of perjury that the information below is correct and complete to the best of my knowledge. I understand that I must report any changes in countable household members that last more than 30 total days during a 12 month Authorization. Providing inaccurate details about my household composition will lead to the conclusion that I provided false and misleading information. I understand that providing false or misleading information to my child care Subsidy Administrator and the Massachusetts Department of Early Education and Care (EEC) may result in the immediate termination of my child care subsidy. I also understand that EEC may require that I repay any improper payments for child care financial assistance that I received after I provided false or misleading information.

CHECK ALL THAT APPLY:

- ☐ I AM LEGALLY MARRIED
  - Spouse's Name and Date of Birth - _____
- ☐ I AM LIVING WITH THE FATHER/MOTHER OF MY CHILD(REN)
  - Father/Mother's Name and Date of Birth - _____
- ☐ I AM LEGALLY DIVORCED
- ☐ I AM WIDOWED
- ☐ I AM LEGALLY SEPARATED FROM MY LEGAL SPOUSE
  - Spouse's Name and Date of Birth - _____
- ☐ I AM INFORMALLY SEPARATED FROM MY LEGAL SPOUSE
  - Spouse's Name and Date of Birth - _____
- ☐ I DO NOT LIVE WITH THE FATHER/MOTHER OF MY CHILD(REN)

PLEASE LIST THE NAME OF EACH MEMBER OF YOUR HOUSEHOLD AND INCLUDE HIS/HER FULL NAME, DATE OF BIRTH AND RELATIONSHIP:

FULL NAME	DATE OF BIRTH	RELATIONSHIP TO THE PARENT

_____ _____
Print Parent Name **Social Security Number**

_____ _____
Signature **Date**

Effective Date: March 1, 2019

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
HOUSEHOLD INCOME STATEMENT

Please read carefully and mark "X" to all that apply. You may be asked to provide documentation of income.

I certify under penalty of perjury that the information below is correct and complete to the best of my knowledge. Providing inaccurate details about my household income will lead to the conclusion that I provided false or misleading information. I understand that providing false or misleading information to my child care Subsidy Administrator and the Massachusetts Department of Early Education and Care (EEC) may result in the immediate termination of my child care subsidy. I also understand that EEC may require that I repay any improper payments for child care financial assistance that I received after I provided false or misleading information.

☐ **I AM CURRENTLY RECEIVING (COMPLETE ALL THAT APPLY - DO NOT LEAVE LINES BLANK, PUT A ZERO IN IF IT DOES NOT APPLY):**

Type of Income	Parent #1 Amount	Parent #1 Frequency *(Monthly, Weekly, etc)*	Parent #2 Amount	Parent #2 Frequency *(Monthly, Weekly, etc)*
Earnings from Employment	$ _____	_____	$ _____	_____
Tips Earned	$ _____	_____	$ _____	_____
Business Income	$ _____	_____	$ _____	_____
Commission	$ _____	_____	$ _____	_____
Child Support	$ _____	_____	$ _____	_____
Alimony	$ _____	_____	$ _____	_____
TAFDC (**NOT SNAP Benefits**)	$ _____	_____	$ _____	_____
DTA Transitional Stipends	$ _____	_____	$ _____	_____
Rental Income	$ _____	_____	$ _____	_____
SSI / SSDI	$ _____	_____	$ _____	_____
Unemployment Compensation	$ _____	_____	$ _____	_____
Workers' Compensation	$ _____	_____	$ _____	_____
Veteran's Benefits (i.e. retirement, disability, etc.)	$ _____	_____	$ _____	_____
Dividends or Income from Trusts/Estates	$ _____	_____	$ _____	_____
Other _____	$ _____	_____	$ _____	_____

☐ **I RECEIVE IN-KIND SUPPORT.** In-kind support can include receiving money from the non-custodial parent for things like: diapers, food, gas, payment of a bill or mortgage, informal alimony, or other forms of support. In-Kind support **does not** include payments made through DOR or the Courts.

The estimated value of this support is: $_____
I receive this support (circle one): *Annually* *Monthly* *Weekly* *Irregularly*

If You are *NOT* Receiving ANY Support:

☐ **I have a court order for child support**, however, I **am not receiving** support at this time.
☐ **I have a court order for alimony**, however, I **am not receiving** support at this time.
☐ **I am NOT receiving any alimony, spousal, child support or other compensation** FROM ANY COURT ORDER OR OTHER AGREEMENT. I do not receive support from any source at this time, including in-kind support.

_____ *(Initial)* **I certify that my household does not have assets with a combined value of more than $1 million. Assets are valuables including, but not limited to, all houses or other buildings, real property, vehicles, cash, bank accounts, cash value of life insurance policies, trusts, stocks, bonds, and overall business value, including equipment, jewelry, livestock, or other goods.**

_____ _____
Print Parent Name **Social Security Number**

_____ _____
Signature **Date**

Effective Date: March 1, 2019

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
EMPLOYMENT VERIFICATION FORM

The Department of Early Education and Care (EEC) provides financial assistance for early education and care to eligible Massachusetts Families. To qualify, Families must meet EEC's income guidelines and must demonstrate a service need. Service need is defined as the amount of time child care is required due to the Parent's (including guardians) participation in an approved activity. Approved activities that establish a service need include employment, education, and training.

This form must be completed by the following applicants:

- A newly employed applicant who cannot yet provide pay stubs documenting his/her income for one month (4 weeks within the most recent 6-week period);
- A self-employed applicant, including independent contractors/contract workers;
- An applicant who is paid in cash, personal check or money order, regardless of whether he/she is employed by or working as an independent contractor/contract worker for an individual or business.

The purpose of this form is to verify:

- an applicant's employment status;
- the number of hours per week that he/she works;
- the amount of income that he/she receives for those hours of work; and
- that a Parent is eligible for EEC financial assistance and, if found eligible, the amount of child care that he/she may receive.

INSTRUCTIONS FOR COMPLETING THIS FORM

Note: *A person's eligibility for EEC financial assistance cannot be determined unless all sections of this form are completed in their entirety and returned to the Subsidy Administrator. It is important that the form be completed and returned in a timely manner.*

Instructions for EEC Financial Assistance Applicant (Parent):

1. Please complete Sections I, II, and III of this form.
2. After completing these sections, you should make and retain copies for your records before giving the form to the person verifying your employment.
3. If you are a new employee or existing employee of a business and you are paid in cash, you must give this form to your employer to complete Section IV and send the form to the Subsidy Administrator.
4. If you are an independent contractor/contract worker, you must give this form to the person/business with whom you contract to complete Section IV and send to the Subsidy Administrator.
5. If you are self-employed, you must give this form to one of your customers/clients or suppliers to complete Section IV and send to the Subsidy Administrator.
6. The person verifying your employment must complete Section IV and must send this form to the Subsidy Administrator.

Instructions for Person Verifying Employment:

Please complete Section IV of this form. Please make and retain a copy for your records and send the original along with any supporting documentation to the Subsidy Administrator.

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
EMPLOYMENT VERIFICATION FORM

SECTION I: EMPLOYMENT INFORMATION

To be completed by the EEC financial assistance applicant.

1. Name of Applicant (Parent):_____

2. Type of Employment

   a. Please check the statement that best describes the nature of your employment.

   ☐ I am a new employee of the business listed below. *Please complete b and e below and skip c and d.*

   ☐ I am an existing employee of the business listed below. *Please complete b and e below and skip c and d.*

   ☐ I work as an independent contractor/contract worker for the business listed below. *Please complete b, c, d and e below.*

   ☐ I am self-employed. *Please list the name and address of your business, if applicable, below in b, then complete c and d, and skip e.*

   b. Name of Business: _____

   Address: _____

   Telephone: _____

   c. If you are an independent contractor/contract worker or are self-employed, please describe the type of work that you perform or the nature of your business (*for example, I drive a taxi cab*).

   _____

   _____

   d. If you are an independent contractor/contract worker or are self-employed, do you perform work for or provide services to multiple clients?

   □ Yes □ No

   e. If you are an employee or independent contractor/contract worker, are you paid in cash or by personal check or money order by the business listed above in b?

   □ Yes □ No

   <u>IF YOU ARE PAID IN CASH</u>, you will be required to provide a copy of your most recent federal income tax returns, including all applicable forms and schedules, as well as a federal income tax return transcript.
   <u>IF YOU ARE PAID BY PERSONAL CHECK OR MONEY ORDER</u>, you will be required to provide copies of cancelled checks or money orders reflecting payment for 4 weeks out of the 6 most recent weeks, as well as copies of your most recent federal income tax returns including all applicable forms and schedules, as well as a federal income tax return transcript.

3. Please list the start date of your employment, the date you began work as an independent contractor/contract worker, or the date you began your self-employment. _____
For example, January 15, 2007

4. How many hours per week do you work? _____hours
If your work schedule varies, please list the minimum and maximum hours per week that you may work (for example, between 20-25 hours per week).

5. How much income, including tips, do you receive per week for these hours of work? _____
If your income varies, please list the average amount of income that you receive per week.

6. Please describe your work schedule each week *(for example, 8:00 a.m. to 4:00 p.m. on Mondays, Wednesdays, and Fridays).*

_____

_____

SECTION II: AUTHORIZATION FOR RELEASE OF INFORMATION

To be completed by the EEC financial assistance applicant.

I am requesting financial assistance for child care from the Department of Early Education and Care. I authorize:

- the individual listed in Section IV to release information requested on this form about me;
- the individual listed in Section IV to share information relating to my employment status, work schedule, and income with the child care resource and referral agency Subsidy Administrator and/or EEC to determine my eligibility for financial assistance; and
- the Subsidy Administrator and/or EEC to contact the individual listed in Section IV to verify the information provided on this form.

I understand that my decision to authorize the individual listed in Section IV to share information about my employment status, work schedule, and income with the Subsidy Administrator and/or EEC is voluntary. However, I understand that if I do not authorize the individual listed in Section IV to share this information, the Subsidy Administrator and/or EEC, will not be able to make a determination about my eligibility for financial assistance for child care.

Print Parent Name: _____ Date: _____

Parent Signature: _____

_____
ADDRESS **CITY** **STATE** **ZIP CODE**

_____ _____
PHONE NUMBER **E-MAIL ADDRESS**

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
EMPLOYMENT VERIFICATION FORM

SECTION III: CERTIFICATION

To be completed by the EEC financial assistance applicant.

I certify that the information provided in Sections I and II of this form is, to the best of my knowledge and belief, true and accurate. **I understand that IF I AM PAID IN CASH, I am responsible for providing a copy of my most recent federal income tax returns, including all applicable forms and schedules, as well as a federal income tax return transcript. I also understand If I am PAID BY PERSONAL CHECK OR MONEY ORDER, I will be required to provide copies of cancelled checks or money orders reflecting payment for 4 weeks out of the 6 most recent weeks, as well as copies of my most recent federal income tax returns including all applicable forms and schedules, as well as a federal income tax return transcript.**

I certify that the information provided on this form is, to the best of my knowledge and belief, true and accurate. I understand that providing false or misleading information in connection with my application for EEC financial assistance, receiving EEC financial assistance as a result of any false or misleading information, and/or the concealing or withholding of information for the purpose of establishing or maintaining eligibility or increasing the level of child care assistance may lead to an immediate termination of my child care subsidy. I also understand that I must **report within thirty (30) days any temporary or non-temporary change.** Temporary changes include: any time-limited absence from a Parent's approved activity due to an illness or need to care for a Family member; any interruption in work for a seasonal worker who is not working between regular industry work seasons; any semester or holiday break for a Parent participating in education or training; any reduction in work, training or education hours, as long as the Parent is still working or attending training or education; any other cessation of a Parent's approved activity that does not exceed 12 weeks; and change in residency within the Commonwealth. Non-Temporary changes include: total household income exceeding 85% SMI; changes in Family contact information; changes in household composition for more than 30 total days in a 12 month authorization; changes in child custody arrangements; any out of state change in address; or any change or cessation of a Parent's work, training, or education participation that lasts more than 12 weeks. I understand that failure to report a non-temporary change may result in an Intentional Program Violation and may be subject to disqualification.

Parent's Signature: _____ Date: _____

SECTION IV: VERIFICATION OF EMPLOYMENT BY THIRD PARTY

To be completed by the person verifying the employment of the EEC financial assistance applicant.
Please check the box below that best describes your business relationship to the applicant.

- ☐ I am the applicant's employer. *If you checked this box, please complete Parts A and C below and skip Part B.*
- ☐ The applicant is an independent contractor/contract worker with whom I contract. *If you checked this box, please complete Parts A and C below and skip Part B.*
- ☐ I am a customer/client of the applicant. *If you checked this box, please skip Part A below and complete only Parts B and C.*
- ☐ I supply goods or services to the applicant as part of his/her business. *If you checked this box, please skip Part A below and complete only Parts B and C.*

Please list below the applicant's start date of employment or, if the applicant is an independent contractor/contract worker with whom you contract, please list the date that he/she first began working for you.

EMPLOYMENT START DATE:_____

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
EMPLOYMENT VERIFICATION FORM

<u>Part A</u>: To be completed by applicant's employer, or if the applicant is an independent contractor/contract worker, by the person/business who contracts with the applicant.

1. Please describe the type of work performed by the applicant, the number of hours that he/she works per week, including weekly schedule, and the amount of income that he/she receives for those hours of work. *For example, I employ Jane Doe as a contract employee to drive a taxi cab on Mondays, Tuesdays, and Fridays from 8:00 a.m. to 6:00 p.m. Jane Doe works 30 hours per week and is paid $300 per week plus tips.*

_____

_____

_____

Please provide the following information about your business.

2. Name of Business:_____
3. Address of Business:_____
4. Business Telephone:_____
5. Nature of Business:_____
6. Social Security Number: _____ **OR** Employer Identification Number (EIN)[1]:_____
7. Corporate Status of Business: (Please check one of the following)

   ____Sole Proprietorship ____Partnership ____Corporation ____S-Corporation

8. Doing Business As (DBA) Certificate Number:_____ *(If applicable)*
9. City/Town Where DBA Was Filed:_____ *(If applicable)*

<u>PART B</u>: To be completed by a customer/client or supplier verifying the employment of the EEC financial assistance applicant.

1. Please check the box below that best describes your business relationship to applicant.

   ☐ I am a customer/client of this applicant.

   ☐ I supply goods or services to this applicant as part of his/her business.

2. How long have you been a customer/client/supplier of the applicant?

_____

[1] Also known as a Federal Identification Number

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
EMPLOYMENT VERIFICATION FORM

3. Please describe the type of work performed by the applicant, including the nature of the goods/services provided. *For example, Jane Doe has her own landscaping business and does landscaping and gardening work.*

_____

_____

4. **If you are a customer/client of the applicant**, how often do you purchase goods/services from this individual? *For example, Jane Doe takes care of my lawn and garden twice a month during the months of April-November.*

_____

_____

5. **If you supply goods or services to the applicant**, how often do you supply goods or services to this individual? *For example, I deliver office supplies to Jane Doe once a month.*

_____

_____

6. Do you know how many hours per week the applicant works and/or his/her hours of operation?

□ Yes □ No

7. If you answered yes to question 6, please list below the weekly work hours and/or hours of operation of the applicant.

_____

_____

Part C: To be completed by all persons verifying employment

I certify that the information provided in Section IV of this form is, to the best of my knowledge and belief, true and accurate.

Please print Verifier's name: _____ Date: _____

Signature of Person Verifying Employment: _____

Verifier's Title _____ Telephone: _____

Address: _____

Instructions for Person Verifying Employment of EEC financial assistance applicant: Please make a copy of this form for your records and return the original form and any supporting documentation to:

Subsidy Administrator enter address or affix mailing label:

_____

_____

_____

FID_____

THE DEPARTMENT OF EARLY EDUCATION AND CARE
SUBSIDIZED CHILD CARE
RESIDENCY CERTIFICATION FORM

The Department of Early Education and Care (EEC) requires that subsidized Child Care recipients be residents of the Commonwealth of Massachusetts. **THIS FORM MAY ONLY BE USED FOR REAUTHORIZATION OF SUBSIDIZED CHILD CARE IF THE PARENT IS UNABLE TO PROVIDE AN EEC APPROVED DOCUMENT CONFIRMING ADDRESS.**

I,_____, attest that:
PARENT'S NAME

Please check appropriate box:

☐ **I am currently a resident of the Commonwealth of Massachusetts and reside at the same address as my last reauthorization located at:**

OR

☐ **I have moved and still currently reside in the Commonwealth of Massachusetts and now live at:**

Physical Address: _____

_____

Mailing Address: _____

_____

Home Number: _____ Work Number: _____

Mobile Number: _____ E-Mail Address: _____

- I understand I must maintain updated contact information, which includes: physical address, mailing address, phone number(s), and e-mail addresses. If my contact information changes during this Authorization period, I must contact my Subsidy Administrator to update my information and complete a Parent Contact Information Form. These changes are expected to be reported immediately, but no later than 30 days from the date of the change.

- I understand that I must be a resident of the Commonwealth of Massachusetts to be eligible for a child care subsidy. Any out of state changes in address may result in termination or denial of my subsidized care.

I certify under the pains and penalties of perjury that the information provided is correct and complete to the best of my knowledge.

Signature of Parent: _____ Date: _____

Print Parent Name: _____

Subsidy Administrator Agency Name: _____

Subsidy Administrator Staff Member: _____

Received on: _____
DATE

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

CHILD SUPPORT INFORMATION FORM

Name:_____

Date:_____

- ❑ **I do not receive child support payments.**
- ❑ **I do receive child support payments:**

Comments:_____
_____
_____
_____
_____

I attest that the above information is true and accurate.

Parent Signature_____

Date: _____