Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name (Last)	(First)	Nickname (If any)

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff who care for your child.

Who is in the child's family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.?
☐ Yes ☐ No? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) ☐ Yes ☐ No? Additional Details?

Are there any cultural or religious practices of your family of which we should be aware? (dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes ☐ No? Additional Details? (center based, in home, with family, with parents, etc.)

How often does your child drink during the day (milk, juice, water, etc.)?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Child Care Licensing requires a form be completed for children with food allergies and/or dietary restrictions)

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

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

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

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

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

What causes your child to feel angry or frustrated?

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

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

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

Where does your child sit at the table? (high-chair, booster seat, etc.)

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

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

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

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

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

Does your child have trouble sleeping? (Night terrors, trouble going to sleep, etc.) ☐ Yes ☐ No? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

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

Child's Name	Date of Birth	First Day at Center
Home Address		City
State / Zip Code	Home Telephone Number	
Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State / Zip	
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State / Zip	
Email Address (if applicable)	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

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

☐ No

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

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

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

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

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

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

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

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

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

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

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Child's Escort / Emergency Contact List

(You are granting permission for your child to be picked up by these persons without any other notification, or contacted in case of emergency.) **All persons must show picture identification at the time of pick up.**

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Name________________________________ Date added__________ Date dropped__________
First Last

Phone # __________________ Cell # __________________ Relationship__________________

Media/Photography release and consent form

Although our parent handbook states: "HKCL reserves the right to use pictures and/or videos of children enrolled in the center, past and present, for advertising and/or internal purposes unless otherwise noted **in writing** by the parent.", we want to ensure all parents understand this policy. We assure you that the photographs are only used to promote the goodwill of the program and allow parents to view the progress of their child via photos. Therefore please read and sign the following:

As the parent of a child/children at HKCL, I agree and give permission to the following:

- I understand that my child(ren) whose name(s) are listed below may be photographed at Heavenly Kids during normal center hours, field trips, or activities.
- I understand that these photographs may be used in center website, newsletters or other social media types.

The following are the names of my children attending Heavenly Kids: (Please print your child's name)

_____

( ) Yes, I confirm that I have read and understood the above, and agree to have my child (rens) photos mounted on the Heavenly Kids website, printed material and all media types (television, facebook)

( ) Yes, my child can be photographed, but I do not want photographs used for external use.

( ) No, I do not wish to have my child (ren) photographed at all.

Print Name _____ Signature:_____ Date:_____

Parent Handbook and Admission Contract receipt

I acknowledge that I have received and reviewed the center's parent handbook along with the admissions contract. I agree to adhere to all policies outlined within.

Child's Name _____ Parent Signature:_____ Date:_____

Director's Signature:_____ Date:_____

Heavenly Kids Center for Learning

Nurturing, teaching and growing children to reach their highest potential

Admission Contract

Heavenly Kids Center for Learning, (herein known as HKCL) is a childcare facility operated by EYE to I Learning, Inc. HKCL is licensed by the State of Ohio Department of Job and Family Services, pursuant to sections of the State Administrative Code 5101.

BASIC SERVICES:

HKCL shall provide the following basic services for:

Child's Name: _____ Parent/Guardian Name: _____

TERMS

1. Children are required to be in attendance daily to prevent losing their slot. Children who have three *unexcused absences* will be withdrawn from the program.
2. **All childcare fees are due prior the start of the week.** A late fee of $25.00 will be accessed after the 5th day of non-payment. **Any delinquent accounts will be turned over to collections after 30 days. An additional amount of 40%, plus filing and/or legal fees will be added to the delinquent amount.**
3. **INCOME TAX STATEMENTS will be provided for all parents that are current with their fees.**
4. **A non-refundable application fee of $50.00 will be due along with registration paperwork in order to hold your spot.**

I agree to the following policies related to my fees:

- Pay the co-pay specified on my ODJFS approval letter to Heavenly Kids Center for Learning. This co pay may be subject to change at the discretion of ODJFS.
- Pay any late fees associated with picking up my child after the 6 PM cut-off .
- Upon leaving HKCL, I am responsible for the full balance that remains on my account.
- Pay a swipe fee of $3.00 for each swipe that is not completed for my child.
- Pay for absent days which exceed those eligible for payment from ODJFS (Title XX recipients receive 10 absent days every 6 months).

I understand that per Heavenly Kids, the maximum hours I am permitted to have my child here is 9 ½ hours per day. If child remains at the center longer, there will be a $12.00 per hour charge (assessed in 15 minute increments).

I agree to cooperate with the general policies of HKCL, to perform the obligations of parent(s) or guardian(s) set forth in this Agreement, and to abide by the rules, regulations, and manuals promulgated and provided by HKCL. My signature (below) indicates that I have read the terms of this agreement and that I have read the rules, regulations, and manuals promulgated and provided by HKCL. It further indicates that I have had this material explained to me and that all of my questions have been satisfactorily answered. I further understand that HKCL reserves the right to withdraw any child whom HKCL deems is not able to meet that child's needs or any child the center is not equipped to provide quality care.

Parent/Guardian Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

404 E. Mound St. * Columbus, Ohio 43215 * (614) 221-5750 * www.heavenlykidslearn.com

Ohio Department of Education - Office for Child Nutrition

A

CHILD AND ADULT CARE FOOD PROGRAM ENROLLMENT FORM

Prototype Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care. If schedule will vary in future due to changes in parent/guardian job schedule, indicate by writing a note on chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e)(2) require that an enrollment form be **updated annually** and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME (please print)	AGE	BIRTHDATE month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care	List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

SIGNATURE OF PARENT/GUARDIAN	DATE	DAY PHONE NUMBER

MAILING ADDRESS: STREET /APT. CITY ZIP CODE

(rev. 2/23/11)

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS FY 2013 – 2014

FY2013 – FY2014 (7/1/13 – 6/30/14) INSTRUCTIONS: To apply for free and reduced-price meals, read the Household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households *Part 2* is to be used only for a child living in a household receiving Food Assistance or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an* adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and is valid for only 12 mo.

CENTER NAME		CHECK IF A FOSTER CHILD (the legal responsibility of a welfare agency or court).	PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER.
PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER			Circle type of benefit: FOOD ASSISTANCE or OWF
* NAME OF ENROLLED CHILD(REN)	AGE / BIRTH DATE		
1.		☐	CASE NUMBER:
2.		☐	CASE NUMBER:
3.		☐	CASE NUMBER:
4.		☐	CASE NUMBER:

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

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	☐	$ 200 / weekly	$ 150 / twice month	$ 100 / monthly	$ /
1.	☐	$ /	$ /	$ /	$ /
2.	☐	$ /	$ /	$ /	$ /
3.	☐	$ /	$ /	$ /	$ /
4.	☐	$ /	$ /	$ /	$ /
5.	☐	$ /	$ /	$ /	$ /
6.	☐	$ /	$ /	$ /	$ /

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

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

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number ☐☐☐☐ (check if applicable) ☐ I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

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

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

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

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

State Distribution: 6/21/2013

THIS SECTION TO BE COMPLETED BY CENTER:

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion :
Weekly x 52, Every 2 Weeks (bi-weekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Categorized as:

☐ **FREE**, based on ☐ Food Assistance/OWF Case No. ☐ Household Size & Income ☐ Foster Child

☐ **REDUCED**, based on Household Size & Income

☐ **PAID**, based on ☐ Income Too High ☐ Incomplete ☐ Invalid case number or information

Total Household Size: _____

Total Household Income: $_____

Per: ☐ Week ☐ Every 2 Weeks ☐ Twice Per Month ☐ Month ☐ Year

Signature of Sponsor / Center Representative	Date Sponsor Categorized	Effective Date (From the first of month of date categorized by sponsor/center)	Expiration Date (Valid until last day of month of which form was dated and categorized by sponsor/center one year earlier)

HOUSEHOLD LETTER - Dear Parent or Guardian:

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

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

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

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCES OR OWF: COMPLETE THIS PART AND PART 4 – If a child is a member of a Food Assistance or OWF household, the child is automatically eligible to receive free CACFP meal benefits subject to application completion.

- Circle the type of benefit received (Food Assistance or OWF).
- List a current Food Assistance or OWF case number for each child. This will be a 10 or 12-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance or OWF case number for each child in Part 2.

PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME & HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE THIS PART & PART 4.

a) Write the names of all household members including yourself and the child(ren) that attends the child care center, whether they receive income or not. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

b) Check the box for any person listed as a household member (including children) that has no income.

c) For each household member, list each type of income received during the last month and list how often the money was received.

1) *Earnings from work before deductions*: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every 2 weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

2) *List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.*

3) *List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.*

4) *List all other income sources.* Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. For only the self-employed, report income after expenses (net income) in column 1 under earnings from work. For your business, farm or rental property report income in column 4. Do not include food assistance payments.

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

a) * All applications must have the signature of an adult household member.

b) * The adult signing the application must also date the form.

c) * Only an application that lists income in Part 3 must have the last 4 digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box "I do not have a Social Security Number." If you listed a Food Assistance or OWF number for each child or if you are applying for a foster child, the last 4 digits of the social security number are not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

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

NON-DISCRIMINATION STATEMENT: The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

REDUCED INCOME ELIGIBILITY GUIDELINES – 185%

Guidelines to be effective from July 1, 2013 through June 30, 2014

Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	YEAR	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	21,257	1,772	886	818	409
2	28,694	2,392	1,196	1,104	552
3	36,131	3,011	1,506	1,390	695
4	43,568	3,631	1,816	1,676	838
5	51,005	4,251	2,126	1,962	981
6	58,442	4,871	2,436	2,248	1,124
7	65,879	5,490	2,745	2,534	1,267
8	73,316	6,110	3,055	2,820	1,410
For each additional family member, add	7,437	620	310	287	144