Dear Parent/Guardian:

Thank you so much for your interest in CORA Early Years: Huntingdon Mills! We are so excited to bring high quality, educational childcare to your community, and we cannot wait for you to join our CORA family! In order to pre-register your child, you must complete the attached registration packet. Once this application has been returned with the required documentation to the Center's Director, I will contact you via email to setup an ***interview with you and your child before you can be approved for this program. Spots are limited, and will be awarded on a first come/first serve basis (considering individual qualifiers.)***

Although your child meets the age requirement (2- the day a child begins kindergarten,) there are other requirements your family must meet in order to participate in this program. Please see the attached checklist on the next form to ensure you have all required documents prior to submitting this enrollment application.

Additionally, due to high demand, the center requires ***a $50.00 deposit/application fee to hold your child's spot***. That payment can be made by cash (in person,) money order, or via credit card thru Tuition Express on our website at:
https://www.coraservices.org/services/early-childhood/early-years-huntingdon-mills/

Please return the fully COMPLETED application along with all of the documents listed by no later than ***Friday, August 21st*** to hold your child's spot for Fall.
If you have any questions, please do not hesitate to contact me at ***mconnell@coraservices.org***

Thank you for allowing us to meet your family's childcare needs.
We cannot wait to help your child develop a lifelong love of learning!

Sincerely,
Melody Connell, M Ed.
Center Director

Enrollment Record Keeping Checklist

Date:_____ **Center: *CORA Early Years Huntingdon Mills***

Room: _____ **Child's Name:_____**

Child Record Documents:

- ☐ Enrollment form/ family questionnaire
- ☐ Emergency Contact/ Parental Consent Form* ***(Email Address Required, all spaces filled in)***
- ☐ Parent Fee Agreement (all spaces filled in)
- ☐ Health Assessment/ Physical w/ **Hearing and Vision*** ***(less than a year old)***
- ☐ Immunization Record* ***(less than a year old)***
- ☐ Dental Exam-**Dental Office Stamp/ Dentist signature*** ***(less than 6 months old)***
- ☐ Designated Guardians
- ☐ Health insurance Card for Child/Family
- ☐ Photograph Consent Form
- ☐ Consent to Exchange Information
- ☐ Consent for Preventive Screenings
- ☐ Getting to Know You Form (complete, with 45 day meeting request)
- ☐ Birth Certificate/ Passport/ Proof of Age
- ☐ List of family members (Same as on CBS Meal Application)
- ☐ PA State Issued ID for parent/guardian (valid)
- ☐ Family Income Information (W2 tax return, 2 biweekly pay stubs, or 1 monthly pay stub)
- ☐ Family Handbook Receipt (received at orientation)
- ☐ Meal Application
- ☐ Individualized Evaluation Plan (I.E.P.)* ***(Most Recent, if applicable)***

Thank you for making sure all documents are current and completed prior to returning the enrollment packet!

NEW CLIENT ENROLLMENT INFORMATION

Child's Name:
First: * _____ **MI:** ____ **Last*:** _____ **Suffix:** _____ (Jr., Sr., I, II, etc.)

Date of Birth: _____ **Gender: *** ☐ Female ☐ Male

Child's Social Security Number: _____---_____---_____

Ethnicity: * ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

SSN Note: SSN is optional and is only used for the Child Clearance process. Enter all 9 digits or leave the field blank. If you do enter all 9 digits, only the last 5 digits will show in this field. All other digits will be masked.

Primary Race: * (Select all that apply)
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific
- ☐ White
- ☐ Unknown
- ☐ Other

Is English the 1st language for the Child? ☐ Yes ☐ No

Primary Guardian:
First: * _____ MI: ____ Last*: _____

Relationship to Child: *
☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Other

Mailing Address: _____

City, State: **PHILADELPHIA, PA** **Zip Code:** _____

Phone:_____**Email:** _____

Is the child homeless? ☐ Yes ☐ No **Is the child adopted?** ☐ Yes ☐ No

If Yes, Child's Age at Adoption: _____

How many siblings (related by blood, marriage, or adoption) reside in the child's household? _____

Including the child, how many people are in the household? _____

In the household, how many people are over the age of 18? _____

What is the Language used in the home? _____

What is the highest education level completed? (Check only one)
- ☐ Up to 8th Grade
- ☐ 9th to 11th Grade
- ☐ High School Diploma ☐ GED ☐ Vocational or Technical Program after High School
- ☐ Some College
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Graduate / Professional School
- ■ Unknown

What is the employment status of the Parent/Guardian? (Select all that apply)
- ☐ Full Time (30 hours/week and over)
- ☐ Part Time (Fewer than 30 hours/week)
- ☐ Student Full Time
- ☐ Student Part Time
- ☐ More than one Part-Time
- ☐ No Employment
- ☐ Seasonal

Highest education level of the birth mother: (if not already listed above)

☐ Up to 8th Grade
☐ 9th to 11th Grade
☐ High School Diploma ☐ GED ☐ Vocational or Technical Program after High School
☐ Some College
☐ Associates Degree
☐ Bachelor's Degree
☐ Graduate / Professional School
☐ Unknown

Child's Birth Weight (Check one below)

☐ Normal (Greater than or equal to 5lbs.8oz.)
☐ Low (Greater than or equal to 3lbs.4oz. but less than 5lbs.8oz.)
☐ Very Low (Less than or equal to 3lbs.4oz.)
☐ Unknown

Birth Mother's Year of Birth: _____

What type of insurance does the child currently have? (Check one below)

☐ CHIP ☐ Medical Assistance ☐ Private Insurance ☐ None ☐ Unknown

Has a Doctor diagnosed the child with any of the following? (Check all that apply below)

☐ Anemia ☐ Asthma ☐ Diabetes ☐ Food Allergies ☐ Obesity ☐ None

Based on the American Academy of Pediatric Standards, are the child's immunizations up-to-date? ■ Yes ☐ No

Does the child have a physician he/she sees regularly? ■ Yes ☐ No

Does the child have a dentist he/she sees regularly? ■ Yes ☐ No

How often do the members of the household read to the child?

■ At least once a day
■ At least once a week
☐ At least once a month
■ Less than once a month

How many children's books are in the home (may include library books)?

☐ Fewer than 5 ☐ 5 – 10 ☐ 11 – 20 ☐ More than 20

Which of the following outreach activities has any member of the household received in the last year?

☐ Emergency/Crisis Intervention
☐ Housing Assistance (subsidies, utilities, etc.)
☐ Transportation Assistance
☐ Mental Health Services
☐ English as a Second Language (ESL) Training
☐ Job Training
☐ Adult Education (GED programs, etc.)
☐ Substance Abuse Prevention or Treatment
☐ Child Abuse and Neglect Services
☐ Domestic Violence Services
☐ Child Support Assistance
☐ Health Education (including prenatal education)
☐ Parenting Education
☐ Assistance to Families of Incarcerated Individuals
☐ Marriage Education Services
☐ Assistance in Obtaining Health Insurance
☐ Assistance in Identifying Health Care Providers
☐ Unknown
☐ None

CO|RA

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b) 3270.181 &182; 3280.124(a)(b),3280.181 &182; 3290.124(a)(b) 3290.181&.182

CHILD'S NAME: ***(As it APPEARS on child's state/ government issued "Birth Certificate")***	Date of Birth: ***(Required)***
MOTHER'S NAME/LEGAL GUARDIAN: ***(Required: Unless Court Order, Incarcerated or Deceased, please specify):***	Home Phone: ***(Required)***
ADDRESS:	
CITY, STATE, and 5- DIGIT ZIP CODE:	E-mail:
Business Name:	Cell Phone:
Address, City, State, and 5-Digit Zip Code:	Business Phone:
FATHER'S NAME/LEGAL GUARDIAN: ***(Required: Unless Court Order, Incarcerated or Deceased, please specify):***	Home Phone:
ADDRESS:	
CITY, STATE, and 5-DIGIT ZIP CODE:	E-mail:
Business Name:	Cell Phone:
Address, City, State, and 5-Digit Zip Code:	Business Phone:
EMERGENCY CONTACT PERSON (s) (list below) ***(Minimum of (3) Individuals Over 18 yrs. Old)***	**Telephone Number (when in care)**
1	
2	
3	
Person (s) Whom Child May Be Released and Address (list below)***(Min. (3) Over 18 yrs. Old)***	**Telephone Number (when in care)** ***(Required)***
1	
2	
3	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER: ***(Required)***	**Phone Number + Area Code:** ***(Required)***
ADDRESS, CITY, STATE, and 5-DIGIT ZIP CODE: ***(Required)***	
Special Disabilities: ***(Copy of IFSP or IEP Required, if applicable)***	**All Allergies (*Listed on Health Assessment)***
Medical or Dietary Information necessary in an emergency situation ***(Dietary Form Required)***	***Medications (List Medications Taken Daily)***
Additional Information on Special Needs of Child ***(Copy of IFSP or IEP Report Required, if applicable)***	
Health Insurance Coverage or Medical Assistance Benefits	**Policy Number** ***(Required)***

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE **X**	ADMIN. OF MINOR FIRST - AID PROCEDURES **X**
TRANSPORTATION BY THE FACILITY IN CASE OF EMERGENCY **X**	WALKS **X**
I allow child in ***Swimming Pool***/Sprinkler **X**	I allow Photos/video **X**

Signature of Parent or Guardian ***(at least one signature required)*** **X**	**Date**
Signature of Parent or Guardian **X**	**Date**

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $	PER MIN-HR	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

CORA EARLY YEARS Huntingdon Mills DENTAL EXAM FORM

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

SECTION 1: Completed by Parent/Guardian

1. **Has your child been to the dentist? _____No _____Yes**
   If "Yes", date of child's last dental visit: _____/_____/_____
2. **Does your child have (or had) cavities or caries? _____No ____ Yes; If "Yes", how many? _____**
3. **Does your child have any problems with his/her teeth, gums, or mouth? _____No _____Yes**
   If "Yes", please describe: _____
4. **How many times a day does your child brush his/her teeth? _____x's**

SECTION 2: Completed by child's Dentist

1. **Date of child's most recent:**

   Dental Examination _____ Teeth Cleaning_____ Fluoride Treatment_____

2. **Has child ever needed dental treatment? _____No _____Yes**
   If "Yes", type of dental treatment: _____

   Has dental treatment been completed? _____No _____Yes
   If "Yes", date of completion: _____/_____/_____
3. **Date of child's next dental visit: _____/_____/_____**

Dental Office Stamp

My signature certifies the accuracy of this information.

Dentist's Signature: _____

Date: _____

Huntingdon Mills
Parental/Guardian Release Form

I, _____, authorize ***CORA Early Years*** to release my child (ren) to the person(s) designated. This is in consonance with the ***CORA Early Years*** Emergency Plan.

Child's Name	**Designated Custodian (s) Name & Relationship**
_____	_____
_____	_____

_____

Signature Relationship Date

_____

Print Name

_____

Street Address

_____

City, State, Zip Code

(Home Phone)_____(Work)_____(Cell)_____

NOTE: Parents and guardians should designate themselves as designated custodians. Friends, neighbors, and other relatives may also be designated, but must show valid photo ID.

PLEASE PRINT CLEARLY.

Permission Form for Use of Student Picture, Voice, Video and/or Full Name On CORA and all Partners Agencies Materials (SDP, Keystone Stars/ PA Keys, ELRC, etc.)

This letter is to both inform you and request permission for your child's picture, voice, video and/or full name to be published on CORA Early Years website and social media accounts.

Student images are used on the Internet to promote student activities and celebrate student work. However, there are potential dangers associated with posting personal identifiable information on a website because global access to the Internet means CORA Early Years, and their partner agencies cannot control who may view the website.

Accordingly, CORA Early Years will not release any information without prior written consent from you as the parent or legal guardian. Please return this form to the Director of the Center to indicate if your child's image, voice, video and/or full name may be used on the Internet. This permission will be applicable to any use of full name, picture, voice or video taken in the school year in which permission is given and will remain in effect until the full name, picture, video or voice is removed from the website or until consent is withdrawn. As parent or legal guardian, you may withdrawal your consent at any time by sending a written letter along with a new form, to the Director of the Center. Thank you for your cooperation.

Check on of the following options:

☐ I/We **GRANT** permission for any photo/image, voice, video, work and/or full name of this student to be published on CORA Early Years/Clarke School and/or School District of Philadelphia's Internet site.

☐ I/We **DO NOT GRANT** permission for any photo/image, voice, video, work and/or full name of this student to be published on the school and/or School District of Philadelphia's Internet site.

In addition, I agree to release and hold harmless CORA Services, Board Members, staff members, The Clarke School, the School District of Philadelphia, its School Reform Commission members and Board of Education, agents, officers, contractors, volunteers, and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's picture, voice, video and/or full name on the Internet.

Student's Name: _____ **Center Name:** **CORA Early Years**

Print Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____

Consent to Exchange Information with Partners

Partner Center: CORA Early Years Huntingdon Mills

Child's Name: _____ Date of Birth: _____

CORA Early Years Huntingdon Mills is a partner to many city, state, and federal agencies who provide resources and support to our program including, The School District of Philadelphia (SDP), The Department of Human Services, the PA Office of Child Development and Early Learning (OCDEL,) PA Child Care Works/ Caring People Alliance (CCIS/ELRC,) CACFP Food Program, Keystone Stars, among others. I understand that information contained in my child's registration/enrollment folder may be shared within these partnerships, and I agree to the following information being shared when applicable.

The following information, included but not limited to, may be shared:

- **Enrollment Application**
- **Family Fee Agreement**
- **Income Documentation**
- **Proof of Birth**
- **Family Size List**
- **CACFP Food Program Application**
- **Immunization/ Health Assessment**
- **Dental Assessment**
- **Emergency Contact/ Parental Consent**
- **Getting to Know You Form**
- **Photos/Videos**

Parent Signature: _____ Date: _____

Consent for Preventive Screenings

Center: CORA Early Years Huntingdon Mills

Child's Name: _____
Date of Birth: _____

In partnership with the Office of Early Childhood Education Screening Program my child may participate in preventive screenings during the school year. Screenings will take place at the center by Philadelphia School District Nurse or other qualified, licensed professionals.

Parents will be informed when screenings are conducted and notified if further evaluations are needed or recommended.

I give permission for my child to receive the following health screenings and assessments:

- **Hearing screening**
- **Vision screening**
- **Dental and oral hygiene screening**
- **Physical health assessment**
- **Height and Weight tracking**
- **Behavior and Development**
- **Others, as needed**

Parent Signature: _____ Date: _____

Getting To Know You!

Enrollment Date: _____

MEETING REQUEST: Parents can request a meeting the center director within 45 days from your child's enrollment date	
Child's Name:	Birthdate:
Parent's Name:	
□ I would like to request a Getting to Know You meeting with my child's center director at the center location. I understand that this meeting will take place 45 days from the date of my child's enrollment date. Choice #1: Date_____ Time_____ Choice #2: Date_____ Time_____ □ I decline the option of having a Getting to Know You meeting with the center director at my child's center location. I will completed the below sections and return this form to the center director within 45 days of my child's enrollment date.	
PARENT/GUARDIAN INFORMATION This section provides CEY with vital information on your expectations, desires and information you feel we need to know about your child.	
Name:	Home Number:
Mobile Number:	Work Number:
Email Address	
Tell us the best way to contact you: □ Home Number □ Mobile Number □ Work Number □ Email	
1. What are your expectations of the program?	
2. Is there a particular aspect of our education program especially important to your family?	
3. Is there information about your family's culture, ethnicity, language or religion that is important for us to know (celebrations, dietary restrictions)?	
4. Would you and/or your family like to be a resource for any cultural awareness activities? □ Yes □ No	
5. Are you interested in volunteer opportunities in our classrooms? □ Yes □ No	
CHILD INFORMATION The section provides CEY with information on your child's likes, dislikes and special needs. Complete this section to the best of your knowledge.	
Describe your child's likes and dislikes.	
List the activities your child enjoys (reading, tummy time, music, playing outdoors, etc.)	
List your child's favorite toys.	
Does your child respond to a nickname? □ Yes □ No If yes, what is it? _____	
Does your child have allergies? □ No □ Yes If yes please list: □ Food _____ □ Environmental _____ □ Medicine_____	

How is the allergy treated?
Is your child completely toilet trained? □ Yes □ No
Provide additional information you feel is important for us to know to provide the best possible care for your child.
CHILD WITH SPECIAL NEEDS INFORMATION The section provides CEY with information on your child's likes, dislikes and special needs. Complete this section to the best of your knowledge.
Does your child have special needs (medical, developmental, social, mental health, etc.)? □ Yes □ No If yes, please complete this section.
List your child's special needs.
Does your child have an Individual Education Plan (IEP) or an Individual Family Service (IEFS)? □ Yes □ No If yes, provide us with a copy of the plan so we can provide the best possible learning experience for your child.
List all programs and/or individuals who work with your child in regard to the above needs. Will you sign a release of information with the program/individual so we may communicate with them about how to provide enhanced support for your child? □ Yes □ No
Provide additional information you feel is important for CEY to know to provide the best possible care for your child.

CEY offers a Getting to Know You meeting to all new families within 45 days of enrollment. To request a meeting, return the attached meeting request form to your center director. If you decline the meeting, you will be required to completed the child information section below and return it to your center director within 45 days of enrollment.

By signing I acknowledge I have read, understand and agree to follow the Getting to Know You program.

Parent's/Guardian's Signature: _____Center Director's Signature: _____

Huntingdon Mills Income Verification Form

CENTER: CORA Early Years: Huntingdon Mills

Parent/Guardian Name: _____

Child's Name: _____

Child's Birthdate: _____

INCOME VERIFICATION*:

Income Source:_____(Paystubs, COMPASS, SSI, OTHER)

Frequency of Pay:_____(Weekly), (Bi-Weekly), (Monthly), or (Annually)

Average Monthly Income*:_$_____

(Weekly = Gross Amount x4; Bi-Weekly = Gross Amountx2; Monthly = Gross Amountx1; Annually = N/A)

Yearly Income:__$_____

(Weekly* = Gross x 52 weeks; Bi-Weekly* = Gross x 26 weeks; Monthly = Gross x 12 months; Annually = Gross)

Verified by:_____

Date:_____

MONTHLY CALCULATIONS	YEARLY CALCULATIONS

COMMENTS:

_____

_____

****Note: If Weekly amount is different then add all four amounts and divide by four, then multiply by 52 weeks; If Bi-Weekly amount is different then add both amounts and average the amount of the two paystubs and multiply by 26 weeks.***

C.B.S.

Kosher Food Program

85 Suite F Tomlinson Road◌Huntingdon Valley, PA 19006

Phone: 215-938-0201/ FAX: 215-938-0205

CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care home or center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly**.**

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us at:

INFO@CBSFOODPROGRAM.COM or fax 215-938-0205

C.B.S. Food Program 85 Tomlinson Road Huntingdon Valley, PA 19006, 215-938-0201..

Step 1:

List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes,* mark the correct boxes next to the child's name and go to Step 4.

Step 2:

You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

How do you report income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write *0* in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children don't have to be U.S. citizens to qualify for meal benefits.
You are in the military	Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

CACFP Meal Benefit Income Eligibility Form

Sharing Information with Medicaid and SCHIP

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to*. Medicaid and SCHIP ONLY use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

☐ **No! I do not** want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name:

_____

Child's Name:

_____

Child's Name:

_____

Child's Name:

_____

Today's Date:

_____

Print Your Name:

_____

Address:

_____

Signature of Parent or Guardian:

_____

If you have questions or need help, please contact **CBSStaff** at **215-938-0201** or **INFO@CBSFOODPROGRAM.COM** .

This institution is an equal opportunity provider.

School Year 2020-2021

Dear Parent or Guardian**:**

CBS offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). Your child may be eligible for free or reduced-price meals, depending on your income. Your child qualifies if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2019 - June 30, 2020		
Household size	Yearly Income	Monthly Income
1	$23,107	$1,926
2	$31,284	42,607
3	$39,461	$3,289
4	$47,638	$3,970
5	$55,815	$4,652

You can find out if your child is eligible by filling out a CACFP Meal Benefit Income Eligibility form. Please be sure to read the instructions carefully. Fill in all the information we request. We can only approve complete forms. Please send the completed form to:

INFO@CBSFOODPROGRAM.COM **or fax 215-938-0205**

C.B.S. *Food Program 85 Tomlinson Road Huntingdon Valley,* ***PA*** *19006,* 215-938-0201..

If we approve your form, your child will be eligible for 12 months. We may check the information in the form, at any time during the year, to confirm that your child was eligible when you applied.

If you disagree with our decision, you have the right to appeal it. In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability. If you have questions or want to request an appeal, please contact **CBS** at **215-938-0201** or **INFO@CBSFOODPROGRAM.COM** .

Thank you for taking the time to apply. We hope your child enjoys CACFP meals!

Sincerely,

Signature

CBS Staff

This institution is an equal opportunity provider.

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of 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 or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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.

Non-discrimination Statement: **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:

MAIL*:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

Source of Income for Children

Sources of Child Income	Examples
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments -Survivors Benefits	A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	A friend or extended family member regularly gives a child spending money
Income from any other source	A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults

Earnings from Work

-Salary, wages, cash bonuses
-Net income from self-employment (farm or business)

If you are in the U.S. Military:
-Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances)
-Allowances for off-base housing, food, and clothing

Public Assistance/Alimony/ Child Support

-Unemployment benefits
-Workers compensation
-Supplemental Security Income (SSI)
-Cash assistance from State or local government
-Alimony payments
-Child support payments
-Veterans benefits
-Strike benefits

Pensions/Retirement/ All other sources of income

-Social Security (including railroad retirement and black lung benefits)
-Private Pensions or disability benefits
-Income from trusts or estates
-Annuities
-Investment income
-Earned interest
-Rental income
-Regular cash payments from outside household

Child and Adult Care Food Program **Child Care Center Meal Benefit Income Eligibility Form** 2020-2021

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

Definition of Household Members: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. (215) 701-2550

Step 1. All Household Members CHILD'S DAYCARE: **CORA Early Years Huntigdon Mills** 2137 East Huntingdon Street, Philadelphia, Pennsylvania 19125

*Names of **Enrolled** Child(ren) in this daycare: Kids attending THIS location — FIRST	LAST	Foster Child	Migrant	Runaway	Homeless	Head Start	*AGE:
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	

***Step 2.** Do any household members (including you) currently participate in one or more of the following assistance programs: **SNAP, TANF, or FDPIR? YES** ☐ **NO** ☐ **(check one)**

If NO> Got to Step 3 **If YES >** Write case number here: * ___ ___ - ___ ___ ___ ___ ___ ___ ___ and proceed to Step 4 (do not complete Step 3)

Step 3. Total Household Gross income and how often it was received e.g. weekly, bi-weekly, twice a month, month

Names of all Household Members (First, Middle Initial, Last) Total # number of people in your house* ☐

Child Income – Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in Step 1 in A 4.
All Adult Household Members (Included yourself) List all Household Members not listed in Step 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

A. **Name** (All Household Members – including yourself)	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income or Child Income	STUDENT-No income
(Example) *Jane Smith*	$ Gross Income/How often	$ Gross Income/How often	$ Gross Income/How often	$____/_____	☐
*	*$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$	☐
*	*$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$	☐
*	*$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$	☐
*	*$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$	☐
*	*$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$	☐
*	*$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$	☐
*	*$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$ ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2x Month	$	☐

Step 4. Contact information and adult signature. EMAIL COMPLETED FORM TO: INFO@CBSFOODPROGRAM.COM

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

*Signature of Adult Here: ______________________________ *Print Name of Adult: ____________________________________ *Date: __________

*Address: ____________________ *Phone Number: ____________________

*City: ____________________ *State: ____ *Zip Code: ________

Last four digits of Social Security Number: XXX-XX-* __ __ __ __ Check if no SSN ❑

Optional. Children's Ethnic and Racial Identities. We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Mark one or more racial identities: ☐ Asian ☐ American Indian or Alaska Native ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American

Don't fill out this part. This is for official use only. **C.B.S. USE ONLY!!! DO NOT WRITE BELOW THIS LINE!**

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

Total Income ________ How Often? ☐ ☐ Bi ☐ ☐ 2 Household size: ________ Eligibility ☐ Free ☐ Reduced ☐ Denied

Categorical Eligibility ❑

Determining Official's Signature Date Confirming Official's Signature Date Follow-up Official's Signature Date

Code:______________________ ☐Renewal ☐Code Change:______________ ☐Change Daycare:______________

Child Enrollment Form 2020-2021

Sponsoring Organization: CBS State Sponsored Food Program **Center**: **CORA Early Years Huntigdon Mills**

Address: 85 Tomlinson Road Suite D Huntingdon Valley, Pa 19006

Address: 2137 East Huntingdon Street, Philadelphia, Pennsylvania 19125

Phone: 215-938-0201

Phone: (215) 701-2550

Fill out all FIELDS (*) in PRINT with Black Ink if left blank-forms will NOT be processed-child(ren) will NOT be placed on roster to receive meals

REQUIRED: ➡ ***Signature** _____ ***Date** _____

Parent/Guardian

REQUIRED: ➡ ***Signature** _____ ***Date** _____

Center Administrator/Home Provider

***Normal Hours of Care** (write in times)*

Monday – Friday Drop Off: _____ Pick Up: _____

* If more than 8 hours of care per day, please attach an explanation to this form.

Saturday Drop Off: _____ Pick Up: _____Sunday Drop Off: _____Pick Up: _____

➡* **DO NOT LEAVE BLANK**! **Daily Expected Meal Service Participation** (please check box-**regardless of age-DO NOT LEAVE BLANK**!)

Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐

Is this child of school age? ☐Yes ☐No If yes, will additional meals be **provided by parents** when school is not in session? ☐Yes ☐N If yes, please specify the meal ☐Breakfast ☐Lunch ☐Snack ☐Supper

---

***Child's FIRST NAME:**

***Child's LAST NAME:**

***Child's Date of Birth:**

If under 12 months, in addition, need Infant Supplement form (0 to 12 months) 3pages

*MM / DD / YY

***Address:**

***Apt.# or Floor** ***City** ***State** ***Zip Code**

***PARENT/GUARDIAN:**

(E-mail):

Parental Contacts: This child care facility participates in the Child and Adult Care Food Program. **C.B.S. State Sponsored Food Program** is the sponsor. In order to receive federal funds, representatives of the sponsoring organization may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

***Telephone (home):** **Telephone (work):**

☐Day ☐Evening ☐Time

☐Letter ☐Telephone (home) ☐Telephone (work)

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

For Sponsor Use Only

Child enrolled on:_____ Child withdrew on:_____