ANN KIDS Day Care Center

Child's Name: _____

DOB: _____

Documents to Bring:

☐ Emergency Contact Form

Date: _____

☐ SSN Form

☐ Food Program Form

Date: _____

☐ Copy of Birth Certificate

☐ Copy of Parents' Photo ID

Type: _____

☐ Medical Assessment & Immunization Record

Date: _____

☐ Medicine Permission Form

Date: _____

☐ Dental Assessment (3+ years old)

Date: _____

☐ Photo Permission

Granted: Yes ☐ No ☐

Do you have ELRC (formerly known as CCIS):

Yes ☐ No ☐

Annual Contract (read and signed upon receiving all the above paperwork)

Date: _____

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	BIRTH DATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF 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.

Day Care Center

10100 Jamison Avenue,
Philadelphia, PA 19116
215-869-0207

Permission to Administer Medications

Date:	
Child's Name:	
Child's DOB:	
Child's Address:	
Child's 4 Last Digits of Social Security	
Doctor's Name:	
Prescription for or fever higher than _____: **Tylenol** (Dosage: _____) **Other:** _____	
Prescription for light scrapes and bruises: **Thin layer of Neosporin**	
Prescription for scrapes that cause light bleeding: **Peroxide to stop the bleeding and disinfect. Call 911 if bleeding does not stop within _____**	
Doctor's Signature:	**Office Stamp:**

I, (parent's name) _____ give permission to Ann Kids Child Day Care Center to administer medication prescribed by the doctor if my child, (child's name) _____, has fever. I will pick up my child within an hour from the phone call. I understand that if no one comes to pick up my child within an hour and the fever does not go down, then Ann Kids will have to take him or her to the emergency room at my expense. I must pick up my child within an hour even if the fever does go down and come back with a doctor's note that my child does not have any contagious diseases and can come back to the center.

Parent's Name:	**Parent's Signature:**

School Year 2023-2024

Kindergarten Application

This is an enrollment application for Ann Kids Kindergarten for children who turn 5-years-old by September 1st, 2023. Kindergarten slot is considered reserved upon submission of this application and the non-refundable deposit in the amount of $260. This deposit goes towards the Kindergarten weekly payment for the first week. The weekly payment of $260 is a flat rate with no deduction for any absences, vacations, holidays, or closures due to inclement weather, power outages, or other situations beyond Ann Kids' control.

Families are responsible for submitting all the remaining paperwork prior to the first day of Kindergarten. Child(ren) may not attend Ann Kids if paperwork is not received by the first day of Kindergarten; however, the received deposit still counts toward the first week of Kindergarten, not the first week of attendance. Families will be required to pay the weekly fee in order to keep their slot.

Information gathered in this application will assist Ann Kids in identifying additional resources necessary to provide the best learning experience for your child(ren).
Personal identifying information included in this application will remain confidential and will only be used by Ann Kids Staff to better serve and communicate with the families.

Application Questions

Child Information

Child's First Name: _____ Child's Middle Name: _____

Child's Last Name: _____

Child's Street Number and Street Name: _____

City: _____ State: _____ Zip code: _____

Does the child currently live in a shelter, transitional or rapid rehousing, or temporarily living in someone else's house? **(Check one)** ☐ Yes ☐ No

Child's Date of Birth: Month _____ / Day _____ / Year _____

Child's Gender **(Check one)**: ☐ Male ☐ Female ☐ Nonbinary

Has your child previously received childcare services? **(Check one)** ☐ Yes ☐ No

Is your child currently receiving Early Intervention services e.g. physical, speech or other types of therapy services? **(Check one)** ☐ Yes ☐ No

Does your child have a current Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP)? **(Check one)** ☐ Yes ☐ No

Does the family participate in any of the following assistance programs?

- Temporary Assistance to Needy Families (TANF) ☐ Yes ☐ No
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) ☐ Yes ☐ No
- Supplemental Nutrition Assistance Program (SNAP) ☐ Yes ☐ No
- Supplemental Security Income (SSI) ☐ Yes ☐ No

Please indicate if any of the following apply?

☐ Foster Care ☐ Kinship Care ☐ Incarcerated Parent ☐ Refugee

Family Information

Caregiver One

Parent/Guardian's First Name: _____

Parent/Guardian's Last Name: _____

Parent/Guardian's Relationship to Child: _____

Parent/Guardian's Address: _____

Parent/Guardian's Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Parent/Guardian's Email Address: _____

Parent/Guardian's Relationship to Caregiver Two: _____

Caregiver Two

Parent/Guardian's First Name: _____

Parent/Guardian's Last Name: _____

Parent/Guardian's Relationship to Child: _____

Parent/Guardian's Address: _____

Parent/Guardian's Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Parent/Guardian's Email Address: _____

Parent/Guardian's Relationship to Caregiver One: _____

Custody Agreement

The program will presume that there are no restrictions regarding a parent/guardian's right to be kept informed of his/her student's school progress and participate in school activities. A parent/guardian will only be prevented from participating in his/her student's education if a signed court order (e.g., divorce decree, custody order, or restraining order) specifically restricts the parent/guardian's access to the student. If restrictions are in place, the parent/guardian with legal custody must submit a signed copy of the court order describing the rights restricted.

Is there a custody agreement for this child that we need to be aware of: (Check one) ☐ Yes ☐ No
If yes, please provide a copy of the Custody Agreement.

Based on the Custody Agreement please specify who should be contacted for the following reasons:

- Enrollment and Discharge: ☐ Caregiver One ☐ Caregiver Two ☐ Both Caregivers
- Attendance and Program Calendar: ☐ Caregiver One ☐ Caregiver Two ☐ Both Caregivers
- Curriculum, Child Progress, Child Records: ☐ Caregiver One ☐ Caregiver Two ☐ Both Caregivers
- Program Activities, Meetings and Policies: ☐ Caregiver One ☐ Caregiver Two ☐ Both Caregivers
- Incident, Illness, and Emergency Contact* ☐ Caregiver One ☐ Caregiver Two ☐ Both Caregivers

**The site will request you to complete an emergency contact form/document to gather more information.*

Demographic Information

Primary household language (where the child lives): _____

Secondary household language (where the child lives): _____

If languages other than those stated above are spoken in the household, please indicate here:
_____

Child's race **(Select all that apply)**:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Multi-racial
- ☐ Native Hawaiian/Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____

Child's ethnicity (check one):

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

Number of people in household where the child lives: _____
(Please include everyone living in this household)

Attestation

By signing this form, you agree to make weekly payments in the amount of $260 flat rate including $260 deposit for the first week of school.

_____

Name of Parent/Guardian

_____

Signature Date

Accepted by

_____

Name of Staff

_____

Signature Date

Day Care Center

10100 Jamison Avenue,
Philadelphia, PA 19116
215-869-0207

PHOTOGRAPHY CONSENT FORM

As the parent of a child/children at Ann Kids Child Day Care, I understand that my child(ren) whose name(s) are listed below may be photographed at Ann Kids Child Day Care Center during normal daycare hours, field trips, or activities. I understand that these photographs may be used in promoting child care services, either in print or on the Internet. I give permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting our child care services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation.

Parent/Guardian Full Name: _____

Relationship To Child: _____

Child(ren)'s Full Name(s): _____

_____

_____

Address: _____

City _____ State: _____ Zip: _____

Parent/Guardian Signature: _____ Date: _____

ANN KIDS
Day Care Center
10100 Jamison Avenue,
Philadelphia, PA 19116
215-869-0207

Dear Parents!

Will you please provide the last 5 digits of your **child's** social security number for our office's administrative records:

Child's Name:

____

Child's SSN Number (last five digits): _ _ _ _ _

◊◊

Helpful Tips:

Are you familiar with ELRC (formerly known as CCIS) program that helps cover child care expenses at day care centers? You can find more information on http://www.philadelphiachildcare.org and check whether your family is eligible. ELRC helps cover tuition throughout the whole year (PHLPreK and PreK Counts programs cover only 5.5 hours of educational time during the school year and doesn't cover summer and holidays).

Does your family currently receive ELRC (formerly known as CCIS) (check all that apply)?

Δ Yes, we do have ELRC

Δ No, we don't have ELRC and plan to apply

Δ No, we don't have ELRC and do not plan to apply

Ann Kids Food Program Enrollment Form Packet Directions:

We are excited to have your child join Ann Kids Food Program – a USDA funded CACFP sponsor! Our meals are both healthy and delicious, made by a professional chef with over thirty years of experience. We deliver hot USDA-approved meals daily, as well as infant formula, pureed food and chopped food. Our goal is to make children healthy, parents happy, and centers proud.

To make it easier and speed up the enrollment process, below are the directions for filling out the Enrollment Form Packet:

- ***Child Enrollment Form*** must be submitted for every child. Every sibling must have an individual form. One Income Eligibility Form may be submitted for children enrolled in same Child Care Center that live in one household. ***Infant Enrollment Form*** must be submitted for every infant in addition to the Child Enrollment Form. We provide formula, pureed, and chopped food, but to do that we must have both forms.
- Please, complete every field on the Child Enrollment Form neatly, please print. All fields on the form are required. To speed up the enrollment process and ensure your child receives nutritious meals the soonest, please make sure you filled out the form correctly. If you have any questions, please ask your child care Director for assistance.
- Please follow the instruction on "2022-2023 Letter to the Parents" to fill out the ***Meal Benefit Income Eligibility Form*** correctly. Ann Kids Food Program will not be able to determine the eligibility without a correctly filled out form. To speed up the enrollment process and ensure your child receives nutritious meals the soonest, please make sure you filled out the form correctly. If you have any questions, please ask your child care Director for assistance.
- ***Participation in this program will NOT affect any other subsidy that you currently receive.***

Thank you for your cooperation!

We look forward to putting a smile on your children's faces!

Ann Kids Food Program
info@annkidsfoodprogram.com
10100 Jamison Avenue,
Philadelphia PA 19116

Child and Adult Care Food Program

Child Enrollment Form

ANNKIDS
AnnKidsFoodProgram.com

Dear Parents: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). **Federal CACFP Regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter.** This information will help ensure all children receive appropriate meals during their care.

Section 1: Family information *Please print*

Child First Name _____ Child Last Name _____

Child Date of Birth ___/___/_____ Age ____

Parent/Guardian Full Name(s) _____

Address: _____ City _____ State _____ Zip _____

Tel. (Home) ___-_____ (Cell) ___-_____ (Work) ___-_____

A representative from Ann Kids Food Program and/or the State Agency may contact you to verify your child's participation in CACFP. Please place a check mark next to the time and method of contact you prefer.

☐ - During Day ☐ - During Evening ☐ - U.S. Mail ☐ - Telephone (Home) ☐ - (Cell) ☐ - (Work)

Section 2: Organization Information

Agreement # _____

Sponsoring Organization:
Ann Kids Inc.
10100 Jamison Avenue
Philadelphia, PA 19116

Participating Location / Center (please circle one):

Ann Kids Jamison
10100 Jamison Ave.,
Philadelphia, PA 19116

Ann Kids Palmetto
6200 Palmetto Street
Philadelphia, PA 19111

Section 3: Expected Daily Hours of Service

Please mark the times for each week day that your chlid is expected to attend the facility, please specify AM or PM.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Time In:							
Time Out:							

Section 4: Expected Daily Meal Service

☐ ***AM Snack*** ☐ ***Lunch*** ☐ ***Supper***

Is the child of school age? ☐ Yes ☐ No
If yes, will additional meals be providedwhen school is not in session? If yes, please specify the meal:
☐ AM Snack ☐ Lunch ☐ Supper

Section 5: Signature of Parent/Guardian

The information provided on this Child Enrollment Form accurately represents my family's expected participation in the CACFP. When changes occur, I agree to inform Ann Kids Food Program.

_____ ___/___/_____
Signature of Parent/Guardian ***Date***

Section 6: For Child Care Representative Use Only

_____ ___/___/_____ ___/___/_____
Signature Child Care Representative ***Date*** ***Enrollment Date***

Section 7: For Ann Kids Food Program Use Only

_____ ___/___/_____ ___/___/_____
Received by, Signature ***Effective Date*** ***Withdrawal Date***

NONDISCRIMINATION STATEMENT:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

fax:
(833) 256-1665 or
(202) 690-7442; or

email:
program.intake@usda.gov

This institution is an equal opportunity provider.

Let's make this world a better place
And put a smile on every face!

CACFP Meal Benefit Income Eligibility Form Instructions
July 1, 2022-June 30, 2023

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:

[Contact Information].

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
July 1, 2022-June 30, 2023

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 **[Name]** at **[Phone Number]** or **[Email Address]**.

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility Form
Letter to Parents (Non-Pricing Centers)
July 1, 2022-June 30, 2023

08/30/2022

Dear Parent or Guardian**:**

Ann Kids offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). Ann Kids receives support from CACFP to serve those meals. CACFP gives more support 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, 2022 - June 30, 2023		
Household size	Yearly Income	Monthly Income
1	$25,142	$2,096
2	$33,874	$2,823
3	$42,606	$3,551
4	$51,338	$4,279
5	$60,070	$5,006

Please fill out a *CACFP Meal Benefit Income Eligibility* form. It will help us find out how much support Ann Kids receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please bring the completed forms to the Ann Kids center your child is enrolled in:

Ann Kids Jamison
Suite 109
10100 Jamsion Avenue
Philadelphia, PA 19116

Ann Kids Palmetto
6200 Palmetto Street
Philadelphia, PA 19111

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

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 need help, please contact Ann Kids at 267-291-0111 or info@annkids.com

Sincerely,

Anna Breyman,
Director and CEO

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "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.

Check all that apply

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Children listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Household Members (Including 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.

Name of Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) [ ]

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - [ ]

Check if no SSN ☐

STEP 4 Contact information and adult signature. This form is not valid without signature and date of adult household member

"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."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

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 reguarly 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	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• 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	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• 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

OPTIONAL Children's Ethnic and Racial Identities (Optional)

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.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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.

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.**

For Official CACFP Sponsor Use Only NOT VALID WITHOUT DETERMINING OFFICIAL'S SIGNATURE AND DATE

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

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ Reduced ○ Denied ○

Determining Official's Signature

Date

Confirming Official's Signature (second check)

Date

Follow-up Official's Signature (For Pricing Institutions - Verification Official)

Date

Effective Date: If the Institution is using the parent/guardian signature date as the effective date, the form must have been signed by the Institution representative within the same month the parent signed the form or the immediately following month.

Children and Adults with Disabilities and Special Dietary Needs

Operators of the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP) are required to make reasonable modifications to Program meals or the meal service to accommodate children or adults (Program participants) with disabilities that restrict the diet.

1. Licensed Medical Authority's Statement for Participants with Disabilities
U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in Program meals for participants whose disabilities restrict their diets. Sponsors, centers, and day care homes must provide modifications for participants on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for Child Nutrition Programs") may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in Pennsylvania includes a:

- Physician,
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the participant's physical or mental impairment restricts the diet;
- An explanation of what must be done to accommodate the participant; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Special Dietary Needs
Program operators may make food substitutions for individual participants who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Program operators are encouraged, but not required, to have documentation on file when making menu modifications within the meal pattern.

Special dietary needs and requests such as those related to general health concerns and personal preferences are not disabilities and are optional for Program operators to accommodate. Meal modifications for non-disability reasons are reimbursable provided that these meals adhere to Program regulations.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act
Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008,* a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Children and Adults with Disabilities and Special Dietary Needs

4. Individuals with Disabilities Education Act
Preschool children, infants, and toddlers with disabilities have additional rights under the *Individuals with Disabilities Education Act* (IDEA). Questions regarding the IDEA's requirements should be directed to the U.S. Department of Education, which is the federal agency responsible for the administration and enforcement of the IDEA.

Child Nutrition Program (CACFP/SFSP) Contact
For more information about requesting accommodations to Program meals and the meal service for participants with disabilities, contact:
Click here to enter local contact name and information.

USDA Nondiscrimination Statement
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

2. **fax**:
   (833) 256-1665 or (202) 690-7442; or

3. **email**:
   program.intake@usda.gov.

This institution is an equal opportunity provider.

Medical Plan of Care for Child Nutrition Programs (CACFP and SFSP)

Please read pages 1 and 2 before completing this form.

Participant's Name	Date of Birth	Age/Classroom
Name of Center/Program/Site		
Name of Parent/Guardian or Participant's Representative	Phone Number of Parent/Guardian/Representative	
Signature of Parent/Guardian or Participant's Representative	Date	

1. Provide an explanation below of how the participant's physical or mental impairment restricts the participant's diet:

2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the participant's needs:

3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.
Foods to be omitted:

Suggested substitutions:

4. Indicate texture modifications, if applicable:

☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ Other:

5. List any required special adaptive equipment:

Name of Physician/Medical Authority & Title (Please Print)	Provider Phone Number
Signature of Physician/Medical Authority	Date

Signing the following section is optional but may prevent delays by allowing the Program to speak with the physician/medical authority.

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ *(medical authority)* to release such protected health information of the participant as is necessary for the specific purpose of Special Diet information to _____ *(center/program/site)* and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning the participant with the childcare/adult care/ summer food program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for the participant. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ *(date)*. This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is **(*circle one*): Parent Guardian Adult participant** or **Representative of participant** listed on this document and has the legal authority to sign on behalf of that person.

Signature: _____ Date: _____

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

[Here is space for the State agency and sponsoring organization to add contact information]

Learn more about CACFP at USDA's website:

https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

¡Buena nutrición hoy significa un mañana más saludable!

Construyendo para el Futuro con CACFP

Esta guardería infantil recibe ayuda del Child and Adult Care Food Program para servir comidas nutritivas a sus niños.

Comidas servidas aquí deben de seguir los requisitos nutricionales establecidos por USDA.

¿Preguntas? ¿Inquietudes?

[Here is space for the State agency and sponsoring organization to add contact information]

Aprenda más información sobre CACFP en el sitio web del USDA: https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
Noviembre 2019

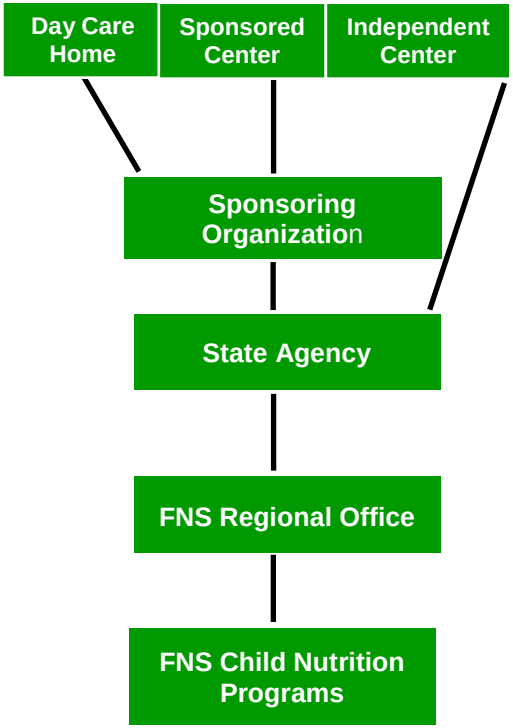
How does CACFP work?

Day care homes and centers receive money for serving nutritious meals. The Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA) oversees CACFP.

States approve sponsors and centers to operate the program. States also monitor and provide training and guidance to make sure CACFP runs right.

Sponsoring organizations support day care homes and centers with training and monitoring. All day care homes participate in CACFP through a sponsor.

CACFP Partners



Contacts

Here is space for the State agency and sponsoring organization to add contact information.

FNS-319
October 2019

Building for The Future

In the Child and Adult Care Food Program (CACFP)

Building for the Future in the CACFP

What is CACFP?

CACFP is the Child and Adult Care Food Program. It is a Federal program that pays for healthy meals and snacks for children and adults in day care.

CACFP improves the quality of day care. It makes the cost of day care cheaper for many low-income families.

Besides providing meals in day care, CACFP makes afterschool programs more appealing to at-risk children and youth. Serving afterschool meals and snacks attracts students to learning activities that are safe and fun.

Children and youth who are homeless can also receive meals at shelters that participate in CACFP.

Here is space for the State agency and sponsoring organization to add contact information.

Who is eligible for CACFP meals?

- Children under age 13,
- Migrant children under age 16,
- Children and youth under age 19 in afterschool programs in low-income areas,
- Children and youth under age 19 who live in homeless shelters, and
- Adults who are impaired or over age 60 and enrolled in adult day care

What kinds of meals are served?

CACFP meals follow USDA nutrition standards.

- Breakfast consists of milk, fruits or vegetables, and grains.
- Lunch and Supper require milk, grains, meat or other proteins, fruits, and vegetables.
- Snacks include two different servings from the five components: milk, fruits, vegetables, grains, or meat or other proteins.

Where are CACFP meals served?

Many types of facilities participate in CACFP.

Child Care Centers:
Licensed child care centers and Head Start programs provide day care with meals and snacks to large numbers of children.

Outside-School-Hours Care Centers:
Licensed centers offer before or afterschool care with meals and snacks to large numbers of school-aged children.

Family Day Care Homes:
Licensed providers offer family child care with free meals and snacks to small groups of children in private homes.

"At-Risk" Afterschool Care Programs:
Centers in low-income areas provide learning activities with free meals and snacks to school-age children and youth.

Emergency Shelters:
Homeless, domestic violence, and runaway youth shelters provide places to live with free meals for children and youth.

Adult Day Care Centers:
Licensed centers provide day care with meals and snacks to enrolled adults.

Did YOU KNOW?

- Even if you receive SNAP, MA or TANF, you may also apply for WIC.
- In most instances, WIC has higher income guidelines than SNAP, MA or TANF. Even if you don't qualify for these programs, you may qualify for WIC.
- Most families in Head Start and Early Head Start qualify for WIC.
- Foster children under age 5 qualify for WIC. Foster parent income is not considered.
- WIC does not require proof of citizenship.

WIC Income Guidelines

Household Size	*Monthly (Approx.)
1	$2,096
2	$2,823
3	$3,551
4	$4,279

For each additional family member, add:

$728

*Income (before taxes) is effective July 1, 2022. For each unborn infant, add one to household size.

How DO I APPLY?

Get started online at pawic.com or call

1-800-WIC-WINS (1-800-942-9467).

pennsylvania
DEPARTMENT OF HEALTH

www.health.pa.gov
www.pawic.com

PA WIC is funded by the USDA. This institution is an equal opportunity provider.

H511.967P Rev. 7/22

PENNSYLVANIA WIC
WOMEN · INFANTS · CHILDREN

Choose Healthy. Choose WIC!

1-800-WIC-WINS

What IS WIC?

WIC is the Special Supplemental Nutrition Program to help improve the health of women, infants and children. WIC services are provided at no cost to you and your family.

"WIC has helped me make healthier choices for my child, and I can save on my grocery bill." -- WIC Mom

Who IS ELIGIBLE?

- **W**omen who are pregnant, breastfeeding or recently had a baby (under 6 months)
- **I**nfants
- **C**hildren under age 5

You must live in Pennsylvania, have a nutrition need and not exceed the income guidelines.

WIC is for married and single parents, working families and the unemployed. If you are a father, mother, foster parent or other legal guardian of a child under age 5, you can apply for WIC for your child.

How CAN WIC HELP MY FAMILY?

Offers screenings and referrals to health care and other services

- Iron testing for anemia
- Immunization, health and lead screenings
- Referrals for SNAP, MA, TANF, CHIP, Healthy Beginnings Plus, Head Start, food banks, etc.

Gives advice for healthy eating

- One-on-one nutrition education
- Nutrition materials
- Online information

Supports breastfeeding

Breastfeeding provides many health, nutritional, economical and emotional benefits to mother and baby. WIC helps mothers continue breastfeeding even if they return to work.

Provides healthy food

- ✓ Milk
- ✓ Cheese
- ✓ Yogurt
- ✓ Soy-based beverages
- ✓ Tofu
- ✓ Fruits and vegetables (fresh, frozen or canned)
- ✓ Dried or canned beans/peas
- ✓ Eggs
- ✓ Peanut butter
- ✓ Canned fish
- ✓ Juice
- ✓ Cereal
- ✓ Whole grains (bread, tortillas, oats, brown rice and pasta)
- ✓ Infant foods
- ✓ Formula and medically necessary supplements