Jackson Mann Community School & Council, Inc.
BCYF, Jackson Mann Community Center
500 Cambridge Street, Allston, MA 02134 (T) 617-635-5153 (F) 617-635-5275
Providing services to the Allston-Brighton Community since 1976; Every Neighborhood, One Mission

Celebrating 40 Years of Serving the Allston/Brighton Community

Hello and welcome to the Jackson Mann Community Center Preschool!

Thank you so much for your interest in enrolling in our preschool program – I look forward to meeting you and your child. Attached to this letter is a packet of paper work that needs to be completed before your child can join our preschool program. **Once you have completed the packet, please call or email me (contact information below) so that we can set up your intake appointment.** At this appointment we will go over all of the paper work, review fee agreements, go through our parent handbook and you will get a tour of the preschool program. Completed paper work and an intake appointment must *both* be completed *prior* to your child starting our program.

In addition the information package, please be sure to have the following with you for your intake appointment:

- ☐ Completed Information Package
- ☐ Current Physical (within one year of intake)
- ☐ Current Immunizations
- ☐ Proof of lead test
- ☐ Birth Certificate
- ☐ Social Security Card for the head of household, if you have one
- ☐ A copy of your voucher, if you have one
- ☐ Applicants not born in the U.S. please bring proof of citizenship, work authorization card or passport
- ☐ Your food stamp benefits letter from Massachusetts Department of Transitional Assistance. Your food stamp card will not be accepted
- ☐ If applicable, any documentation of Early Intervention, Individual Education Plan or support services received by your child
- ☐ If applicable, documentation of required medications to be completed by your child's doctor. Please request these forms from the preschool director PRIOR to enrollment.

If you have any questions about completing the packet or about our program, please call me at 617-635-5153, or email me at preschooldirectorjmcc@gmail.com.

Welcome to JMCC Preschool!

Tricia Cunningahm

Preschool Director

CHILD'S FACT SHEET/ENROLLMENT FORM

FOR CENTER USE:
Date of Admission: ____________
Age at Admission: ____________

CHILD INFORMATION:

Child's Name: ____________________
Date or Birth: ____________________ Place of Birth: ____________________
Home Address: ____________________
____________________ Primary Language: ____________________
Telephone: ____________________

Child's Identifying Information (required by the Office for Children Regulations):

Eye Color: __________ Hair Color: ____________ Sex: _______

Height: _____________ Weight: ______________ Skin Color: ________

Identifying Marks: ____

Allergies: ____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: __________________ Parent/Guardian Name: __________________

Relationship to Child: __________________ Relationship to Child: __________________

Home Address: ______________________ Home Address: ______________________

Home Telephone #: ____________________ Home Telephone #: ____________________

Bus. Name: _________________________ Bus. Name: _________________________

Bus. Address: _______________________ Bus. Address: _______________________

Telephone #: ________________________ Telephone #: ________________________
email: ________________________ email: ________________________
Hours at work: ______________________ Hours at work: ______________________
If parents cannot be contacted, Notify: (include on emergency release form)

Name: ____________________________ Name: ____________________________

Address: __________________________ Address: __________________________

Relationship to Child: __________________ Relationship to Child: __________________

Telephone # (daytime): ________________ Telephone # (daytime): ________________
Others in Family: ____

Child's Physician/Clinic: ____________________________ Telephone #: ________________

____
Parent/Guardian Signature Date

With concerns about the increase in tooth decay (cavities) among young children, the Massachusetts Department of Early Education and Care (EEC) recently adopted a new regulation for child care settings, number 606 CMR 7.11(11)(d), to promote oral health and prevent tooth decay. While we ha always ensured the proper brushing of teeth at the preschool after lunch time, please note the new regulations.

Effective January 2010, child care workers must assist children with brushing their teeth if:

1. **the children are in care for more than 4 hours, or**
2. **They have a meal while in care**

Some quick facts about the program:

- This program will be implemented safely by fallowing the regulations for infection control set b the U.S. Centers for Disease Control and Prevention (CDC)
- It will be a great benefit for your child at NO COST TO YOU
- Children will be brushing with the direct supervision of our child care staff
- Children will be using toothpaste with fluoride and approved by the American Dental Association
- Children will receive a new toothbrush after three months of use, or after they are sick

Please acknowledge that you have read this note regarding the new tooth brushing program. If you hav any questions or concerns, please let us know!

Childs Name:_______________________________

Parent's Name:_______________________________

Signature:_______________________________

Date:_______________________________

Comments:

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME: ________________________________ **DATE OF BIRTH:** ________________

Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting: ___________ crawling: ___________ walking: _________ talking: __________

*Does your child pull up? ___________ *Crawl? ____________ *Walk with support? ___________

Any speech difficulties? ____

Special words to describe needs ____

Language spoken at home _____________________ *Any history of colic? ________________

*Does your child use pacifier or suck thumb? ____________ *When? ________________________

*Does your child have a fussy time? __________________ *When? ________________________

*How do you handle this time? ____

HEALTH

Any known complications at birth? ____

Serious illnesses and/or hospitalizations: ____

Special physical conditions, disabilities: ____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: ____________________

____

____

Regular medications: ____

EATING HABITS

Special characteristics or difficulties: ____

*If infant is on a special formula, describe its preparation in detail: ________________________

____

Favorite foods: ____

Foods refused: ____

* Is your child fed held in lap?__________ High chair?__________
* Does your child eat with spoon?__________ Fork?__________ Hands?__________

TOILET HABITS

*Are disposable or cloth diapers used? ________*Is there a frequent occurrence of diaper rash?______

*Do you use: oil:_____ powder:_____ lotion:_____ other:______________________________

*Are bowel movements regular?______________________ How many per day?______________

*Is there a problem with diarrhea?______________________ Constipation? ______________

*Has toilet training been attempted?____

*Please describe any particular procedure to be used for your child at the center: ______________

____

*What is used at home? Pottychair? ________ Special child seat? _________ Regular seat? ________

*How does your child indicate bathroom needs (include special words): ______________________

Is your child ever reluctant to use the bathroom? ______________________________________

Does your child have accidents? ____

SLEEPING HABITS

*Does your child sleep in a crib? ________ Bed? ________

Does your child become tired or nap during the day (include when and how long)? _____________

____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

When does your child go to bed at night? ____________ and get up in the morning? _____________

Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) ___________

____

SOCIAL RELATIONSHIPS

How would you describe your child? ____________________

____

Previous experience with other children/day care: ____________________

____

Reaction to strangers: ____________ Able to play alone? ____________

Favorite toys and activities: ____________________

Fears (the dark, animals, etc.): ____________________

How do you comfort your child? ____________________

What is the method of behavior management/discipline at home? ____________________

____

What would you like your child to gain from this childcare experience? ____________________

____

DAILY SCHEDULE

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. ____________________

____

____

____

Is there anything else we should know about your child? ____________________

____

____

____________________ ____________________

(Parent/Guardian Signature) (Date)

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME________________________________

MY CHILD WILL ARRIVE AT THE PROGRAM:

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

I give permission for my child to be released from the program at the end of the program day as stated above and /or I give permission to the following people to receive my child at the end of the day. (If no one is authorized other than the parent/legal guardian please indicate below "NO ONE".)

*IF A CHILD IS PROTECTED BY A RESTRAINING ORDER PLEASE SUBMIT ORDER TO THE PROVIDER.

NAME________________________

RELATIONSHIP________________________

ADDRESS________________________

PHONE________________________ CELL________________________

NAME________________________

RELATIONSHIP________________________

ADDRESS________________________

PHONE________________________ CELL________________________

NAME________________________

RELATIONSHIP________________________

ADDRESS________________________

PHONE________________________ CELL________________________

PARENT/GUARDIAN SIGNATURE________________________________ DATE________________

Sun block/insect repellent permission

For protection, we will have your child wear a summer program t-shirt as well as applied skin protection. We ask for your permission to put sunblock with UVB and UVA protection of SPF 15 or higher to exposed areas on your child. Please complete the following permission slip so we may apply sun block to your child each time they are preparing to go outside.

I ________________________________, give permission to the Jackson/Mann
Parent name
Preschool Program to apply sunscreen, SPF 15 or higher, on my child
________________________.
Child's name

When public health authorities recommend use of insect repellents due t a high risk of insect-borne disease, only repellents containing DEET will be used. We will apply insect repellent no more than once a day and only with written permission.

I ________________________________, give permission to the Jackson/Mann
Parent name
Preschool Program to apply insect repellent containing DEET on my child
________________________.
Child's name

Parents Signature ____ Date__________

Field Trip Consent Form

I give permission for my child ____________________________________ to participate in local walking field trips taken by the Jackson Mann Community Center Preschool.

These field trips will include walks to: the Hano St. Park, Davis St. Park, Columbia St. Park, Sorrento Park, Lawrence School Park, Oak Square, Union Square, the Police and Fire Stations, St. Elizabeth's Hospital, and local Allston/Brighton and Brookline businesses.

I understand that when the Jackson Mann Community Center Preschool takes field trips which require transportation, I will be asked to give my written permission for each field trip.

Parent/Guardian Signature: ____

JACKSON MANN COMMUNITY CENTER PRESCHOOL

PERMISSION AND RELEASE FORMS

I give permission for the Preschool to put my address and telephone number on a Parent Community List. Copies will only be given to Preschool families.

Date: ____________________ Parent Signature: ______________________________________

STUDENT OBSERVERS NOTIFICATION FORM

I understand that the Preschool will have student teachers, field workers and observers from area Universities scheduled in each of the classes during the academic year. Each of these students are at the Center to receive training in conjunction with current coursework.

Date: ____________________ Parent Signature: ______________________________________

EVALUATION PERMISSION FORM

I give permission for my child ____ to be evaluated by means of standardized tests or projective techniques, administered within the classroom setting by a student under supervision.

(Regardless of parental permission, a child's decision not to participate at anytime will be final)

Restrictions: ____

____

Date: ____________________ Parent Signature: ______________________________________

PHOTOGRAPHY RELEASE

I authorize the Preschool to use any photographs, video tapes, or slides of my child _______________

_______________ for promotion and recruitment purposes.

Date: ____________________ Parent Signature: ______________________________________

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: ______________________________ Date of Birth: __________________

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

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

Child's Physician Name: ______________________________
Address: ______________________________
Phone Number: ______________________

Child's Allergies: ______________________________
Chronic Health Conditions: ______________________________

Emergency Contacts (*In order to be contacted*)

Name______________________________
Address______________________________
Relationship to child______________________________
Home Phone__________________________ Cell Phone______________________________
Do you give permission for child to be released to this person? Yes_____ No_____

Name______________________________
Address______________________________
Relationship to child______________________________
Home Phone__________________________ Cell Phone______________________________
Do you give permission for child to be released to this person? Yes_____ No_____

Name______________________________
Address______________________________
Relationship to child______________________________
Home Phone__________________________ Cell Phone______________________________
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage______________________________ Policy #______________
Parent/Guardian Name: ______________________________ Phone__________ Cell__________
Parent/Guardian Name: ______________________________ Phone__________ Cell__________

____
Parent /Guardian Signature

____
Date (valid for one year)

Physicians Health Examination

Pat Numb: Name DOB Sex
Address Phone
Address Provider
City

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
DPT					
POLIO					
MMR					
HIB-CONJUGATE					
HEP B					
VARIVAX					
TB TINE					

SAMPLE

History - Including major medical, developmental, or allergic problems

Allergies Y/N? Comments:

Chicken Pox Y/N? Date of Infection

LABORATORY TESTS	DATE	RESULTS
HEMOGLOBIN		
LEAD TEST		

Physical Exams - Most recent and current medications

Date Height Weight

Comments: BP

This physical exam is normal unless noted below:

This patient is fit for competitive sports and physical education unless noted below:

Physician's Address

Telephone:

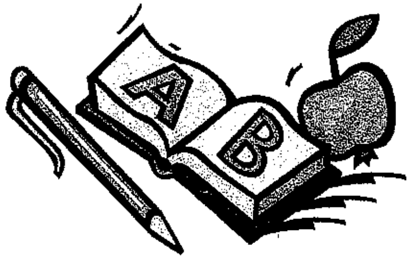
Form Date

Doctor's signature:

Alternative record form for PH-M-18 Mass Department of Health. Alternative for NH, NY, ME, VT.

Doctor's name:____________________

What to bring to Preschool Checklist



For cubby:

- ☐ Diapers and Wipes (if potty training)
- ☐ A shirt (replace seasonally)
- ☐ A pair of pants or shorts (replace seasonally)
- ☐ A pair of underwear (more, if potty training)
- ☐ A pair of socks
- ☐ Rain or snow boots (seasonal)
- ☐ Towel and bathing suit for water play during warm weather
- ☐ Extra pair of gloves or mittens
- ☐ Extra hat for cold weather

What your child should have each week:

PARENTS THIS IS REQUIRED BY THE STATE FOR NAP TIME
AND
MUST BE WASH EVERY WEEK AND RETURNED BACK TO SCHOOL

- ☐ Twin fitted sheet for nap time
- ☐ Small blanket for nap time

Friendly Reminders

- ❖ **Parents please sign In/out daily**
- ❖ **Check your Childs mailbox at lease every day or once a week**
- ❖ **Everything must be labeled**
- ❖ **REMEMBER WE ARE A PEANUT FREE SCHOOL SO NO PEANUTS OR TREE NUTS OF ANY KIND**

Preschool's Daily Schedule

* If conditions pose a health risk as defined by local health officials when going outdoors both Classrooms will go to Open Space

Times	Activities
7:00-7:30	Welcome
7:30-8:00	AM Snack
8:00-9:30	Teacher-Directed Activity &Choices
9:30-10:00	Breakfast
10:00-10:15	Morning Circle
10:15-11:00	Teacher-Directed Activity and Choices
11:00-12:00	Gross Motor @ Ringer Playground
12:00-12:45	Lunch Time
12:45-1:00	Bathroom and Brush Teeth
1:00-3:00	Nap Time
3:00-3:30	Snack Time
3:30-4:00	Free Choice/ Computer M,T,W
4:00-5:00	Gross Motor @ ELC Playground
5:00-6:00	Teacher Read-Aloud & Teacher Directed Activity

Attachment J-2

Child and Adult Care Food Program
Enrollment Statement

______________________________, age ________ is enrolled at
(Name of Child)

the Jackson Mann Community Center Preschool Program.

at 500 Cambridge Street, Allston, MA 02134

Beginning on ______________________________
(Month/Day/Year)

Signature ______________________________ ____________
Parent/Guardian Date

Signature ______________________________ ____________
Center Official Date

In the operation of USDA's food service programs, no one will be discriminated against because of race, color, national origin, sex, age, or disability. If you believe you have been discriminated against, write to: Administrator, Food and Consumer Services, U.S. Department of Agriculture, 3101 Park Center Drive, Arlington, VA 22302.

For Center Use Only

Child withdrawn on ______________________________
Date

Medical Records Consent Form

I, ________________________, *(parent/guardian)* give permission for the Jackson/Mann Community Preschool staff to have access to health information on my child ___________________ *(child's name)*.

I understand this information will be kept confidential and is to be used solely in cases of emergency to obtain necessary medical treatment, when additional written consent has been given to administer medications as well as the maintaining of records on my child.

____

Parent/Guardian Signature *Date*

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **[Name of Center]** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [(Name of Center, address, phone number].**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) or Temporary Assistance for Families of Dependent Children (TAFDC), benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

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

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **[name, address, phone number].**

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **[phone number].**

Sincerely,

[signature]

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 6: Answer this question if you choose.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

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

Part 2: Skip this part.

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

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

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

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

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

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

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

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

Part 6: Answer this question if you choose.

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

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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

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

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

NAME:____ CASE NUMBER: __________________________

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

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

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

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

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: ______________________________ Print name: ______________________________

Date: ____________________

Address: ______________________________ Phone Number: ________________

City:________________________________ State: ____________ Zip Code: ____________

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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

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

Total Income: ____________ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: ________

Categorical Eligibility: ___ Eligibility: Free___ Reduced___ Denied___

Reason: ____

Determining Official's Signature: ______________________________ Date: ____________

Confirming Official's Signature: ______________________________ Date: ____________

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

Effective July 1, 2016 to June 30, 2017	
Household size	**Yearly**
1	21,978
2	29,637
3	37,296
4	44,955
5	52,614
6	60,273
7	67,951
8	75,647
Each additional person:	+ 7,696

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

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race,
color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

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

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

This institution is an equal opportunity provider.

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

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

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

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

If you checked no, fill out the form below.

Child's Name: ______________________________

Child's Name: ______________________________

Child's Name: ______________________________

Child's Name: ______________________________

Signature of Parent/Guardian: ______________________

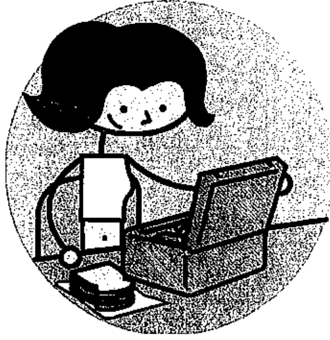
Today's Date: ____________

Print Your Name: ____________________________

Address: ________________________________

____

For more information, you may call **[name]** at **[phone]**



If your child is eligible for free or reduced school meals, your child may also be eligible for

free or low cost health insurance

through MassHealth.

To learn more call: 1-800-841-2900

MassHealth

Si su niño es eligible para almuerzo gratís o reducido, su niño pueda ser eligible para

seguro de salud gratís o de bajo costo

por medio de MassHealth.

Para saber mas, llame al: 1-800-841-2900

Covering Kids

Rev. ESE July 2016

Child Enrollment Form
Child & Adult Care Food Program

Dear Parent/Guardian:

Your child care center ____________________ participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, the child care center has agreed to follow the USDA guidelines. The child care center will give you a copy of the minimum meal components and portion requirements to be served according to the child's age. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP.

In an effort to assess that these requirements are being met, the USDA and CACFP requires child care centers to annually collect the enrollment information listed below.

Please complete the form and return it to your child care center. Part 1 and Part 3 need to be completed by all families or guardians. Part 2 is to be completed ONLY if enrolling an infant child (under the age of 12 months).

PART 1: CHILD ENROLLMENT INFORMATION

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM ✓ Box ☐ Schedule Varies	Hours from: ________ to ________ ________ to ________	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM ✓ Box ☐ Schedule Varies	Hours from: ________ to ________ ________ to ________	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack
Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care
Times Child Normally Attends For example 7:30 AM – 5 PM ✓ Box ☐ Schedule Varies	Hours from: ________ to ________ ________ to ________	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

If there are other children in care, please complete additional forms as needed.

FOR SPONSOR OFFICE USE ONLY

Effective Date of this Enrollment Form: ________________________ Fiscal Year ________________

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The child care center must meet the meal component requirements based on age and development outlined in the Infant Meal Pattern. The child care center will give you a copy of the minimum meal components and portion requirements to be served according to the child's age.

I understand that this child care center will serve a USDA approved formula _______________ to my infant while in care.
(Name of Iron Fortified Infant Formula)

To help provide the best nutritional care for your infant, please complete the following information.
IF YOU *FORMULA-FEED* YOUR INFANT, PLEASE CHECK ONE OPTION

☐ I prefer to have the center supply the formula offered. **OR** ☐ I will supply formula for my infant child.

IF YOU *BREAST-FEED* YOUR INFANT, PLEASE CHECK

☐ I will supply expressed (pumped) breast milk for my infant child.

I understand that this child care center will supply infant cereal and infants foods for infants 4 months and older as they are developmentally ready according to the CACFP requirements.

☐ I prefer to have the center supply infant cereal and infant foods. **OR** ☐ I will supply infant cereal and infant foods for my infant child

PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form and the "Building For The Future" Flyer.

Parent's Signature   Date Signed (form must be completed annually)

Parent's Name: ______________________ Home Phone: ____________
: Please Print

Mailing Address: ______________________ Work Phone: ____________

City, State, Zip: ______________________ Cell Phone: ____________

CIVIL RIGHTS: This information is voluntary and will not affect your children's eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.

1. **Ethnic Identity** ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO.
2. **Racial Identity** ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ WHITE.

For questions please contact: Sponsor or Child Care Center, Contact Name, Address, and Telephone Number

This institution is an equal opportunity provider.

Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.
Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool care programs in needy areas.

Contact Information If you have questions about CACFP, **please contact the following Child Care Sponsor**:

State Agency **Sponsor**

MA Department of Elementary and Secondary Education
Office for Food and Nutrition Programs
75 Pleasant Street
Malden, MA 02148-4906
781-338-6480

English Version

This institution is an equal opportunity provider.

CACFP INFANT MEAL PATTERN

Breakfast

Birth - 3 months	4 - 7 months	8 - 11 months
4-6 fl.oz. formula[1]or breast milk[2,3]	4-8 fl.oz. formula[1] or breast milk[2,3] 0-3 Tbsp. infant cereal[1,4]	6-8 fl.oz. formula[1] or breast milk[2,3] and 2-4 Tbsp. infant cereal[1] and 1-4 Tbsp. fruit and/or vegetable

Snack

Birth - 3 months	4 - 7 months	8 - 11 months
4-6 fl.oz. formula[1] or breast milk[2,3]	4-6 fl.oz. formula[1] or breast milk[2,3]	2-4 fl.oz. formula[1], breast milk[2,3], or fruit juice[5] 0-½ bread[4, 6] or 0-2 crackers[4, 6]

Lunch and Supper

Birth - 3 months	4 - 7 months	8 - 11 months
4-6 fl.oz. formula[1] or breast milk[2,3]	4-8 fl.oz. formula[1] or breast milk[2,3] 0-3 Tbsp. fruit and/or vegetable[4] 0-3 Tbsp. infant cereal[1,4]	6-8 fl.oz. formula[1] or breast milk[2,3] and 1-4 Tbsp. fruit and/or vegetable and 2-4 Tbsp. infant cereal[1] and/or 1-4 Tbsp. meat, fish, poultry, egg yolk, cooked dry beans or peas; or ½-2 oz. cheese; or 1-4 oz. cottage cheese, cheese food, or cheese spread

[1] Infant formula and dry infant cereal shall be iron-fortified.
[2] It is recommended that breast milk be served in place of formula from birth through 11 months.
[3] For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered, with additional breast milk offered if the infant is still hungry.
[4] A serving of this component shall be offered when developmentally ready.
[5] Fruit juice shall be full-strength and served in a cup.
[6] Bread and bread alternates shall be made from whole-grain or enriched meal or flour.

This institution is an equal opportunity provider.

Child Care Meal Pattern

Breakfast

Select All Three Components for a Reimbursable Meal

Food Components	*Ages 1-2*	*Ages 3-5*	*Ages 6-12*[1]
1 milk[2]			
fluid milk	1/2 cup	3/4 cup	1 cup
1 fruit/vegetable			
juice,[3] fruit and/or vegetable	1/4 cup	1/2 cup	1/2 cup
1 grains/bread[4]			
bread or	1/2 slice	1/2 slice	1 slice
cornbread or biscuit or roll or muffin or	1/2 serving	1/2 serving	1 serving
cold dry cereal or	1/4 cup	1/3 cup	3/4 cup
hot cooked cereal or	1/4 cup	1/4 cup	1/2 cup
pasta or noodles or grains	1/4 cup	1/4 cup	1/2 cup

[1] Children age 12 and older may be served larger portions based on their greater food needs. They may not be served less than the minimum quantities listed in this column.
[2] Milk served must be low-fat (1%) or non-fat (skim).
[3] Fruit or vegetable juice must be full-strength.
[4] Breads and grains must be made from whole-grain or enriched meal or flour. Cereal must be whole-grain or enriched or fortified.

Lunch or Supper

Select All Four Components for a Reimbursable Meal

Food Components	*Ages 1-2*	*Ages 3-5*	*Ages 6-12*[1]
1 milk[2]			
fluid milk	1/2 cup	3/4 cup	1 cup
2 fruits/vegetables			
juice,[3] fruit and/or vegetable	1/4 cup	1/2 cup	3/4 cup
1 grains/bread[4]			
bread or	1/2 slice	1/2 slice	1 slice
cornbread or biscuit or roll or muffin or	1/2 serving	1/2 serving	1 serving
cold dry cereal or	1/4 cup	1/3 cup	3/4 cup
hot cooked cereal or	1/4 cup	1/4 cup	1/2 cup
pasta or noodles or grains	1/4 cup	1/4 cup	1/2 cup
1 meat/meat alternate			
meat or poultry or fish[5] or	1 oz.	1½oz.	2 oz.
alternate protein product or	1 oz.	1½ oz.	2 oz.
cheese or	1 oz.	1½ oz.	2 oz.
egg or	1/2	3/4	1
cooked dry beans or peas or	1/4 cup	3/8 cup	1/2 cup
peanut or other nut or seed butters or	2 Tbsp.	3 Tbsp.	4 Tbsp.
nuts and/or seeds[6] or	1/2 oz.	3/4 oz.	1 oz.
yogurt[7]	4 oz.	6 oz.	8 oz.

[1] Children age 12 and older may be served larger portions based on their greater food needs. They may not be served less than the minimum quantities listed in this column.
[2] Milk served must be low-fat (1%) or non-fat (skim).
[3] Fruit or vegetable juice must be full-strength.
[4] Breads and grains must be made from whole-grain or enriched meal or flour. Cereal must be whole-grain or enriched or fortified.
[5] A serving consists of the edible portion of cooked lean meat or poultry or fish.
[6] Nuts and seeds may meet only one-half of the total meat/meat alternate serving and must be combined with another meat/meat alternate to fulfill the lunch or supper requirement.
[7] Yogurt may be plain or flavored, unsweetened or sweetened.

This institution is an equal opportunity provider.