## Missouri Department of Health and Senior Services
### Section for Child Care Regulation / Bureau of Community Food & Nutrition Assistance

---

### Child Care Enrollment Form

<table>
<thead>
<tr>
<th>Facility/Provider Name</th>
<th>Admission Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child's Name</td>
<td>Gender</td>
<td>Birthdate</td>
</tr>
</tbody>
</table>

**Address (Street, City, State, Zip Code)**

---

### Identifying Information

- **Mother's/Guardian's Name**: Home Telephone Number
- **Address (Street, City, State, Zip Code) or check if same as above**: Cell Phone Number

**E-Mail Address**

---

**Employer or School Attend**: Work/School Schedule

**Employer/School Address (Street, City, State, Zip Code)**: Work Telephone Number

**Father's/Guardian's Name**: Home Telephone Number

**Address (Street, City, State, Zip Code) or check if same as above**: Cell Phone Number

**E-Mail Address**

---

### Emergency Contact and Persons Authorized to Take Child from Facility (Other Than Parent) At Least One Emergency Contact Is Required.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship To Child</th>
<th>Telephone Numbers (Cell, Work, Home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, City, State, Zip Code)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name**

**Address (Street, City, State, Zip Code)**

---

### Comments on Child's Development

(Personal development, behavior, patterns, habits, & individual needs)

---

### Related Child

**Check Here What Days the Child Will Attend**: Full Time or Part Time

<table>
<thead>
<tr>
<th>CACFP Requirement</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM PM</td>
<td>AM PM</td>
<td>AM PM</td>
<td>AM PM</td>
<td>AM PM</td>
<td>AM PM</td>
<td>AM PM</td>
<td>AM PM</td>
</tr>
</tbody>
</table>

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### Child's Projected Attendance Schedule and Any Variations Expected

- **Check Here What Days the Child Will Attend**: Full Time or Part Time
- **Check Here What Time Does Your Child Usually Arrive Each Day? Circle AM or PM**: AM PM
- **Check Here What Time Does Your Child Usually Leave Each Day? Circle AM or PM**: AM PM

---

### Write Any Comments, Changes or Variations in Usual Attendance in This Section Including Shift Changes.

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**MO 580-2994 (11-15)**

**Please Also Complete Page 2**

**SCCR/CACFP**

**Page 1**
### Check the Meals Your Child Is Usually Given at This Facility

- [ ] Breakfast
- [ ] Morning Snack
- [ ] Lunch
- [ ] Afternoon Snack
- [ ] Dinner
- [ ] Evening Snack
- [ ] None

### Check the Holidays Your Child Is In Care at This Facility

| CAFCP Requirement                  | Facility
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ New Year's Day (January)</td>
<td>☐ Martin Luther King Jr.'s Birthday (January)</td>
</tr>
<tr>
<td>☐ Memorial Day (May)</td>
<td>☐ Independence Day (July)</td>
</tr>
<tr>
<td>☐ Veterans Day (November)</td>
<td>☐ Labor Day (September)</td>
</tr>
<tr>
<td>☐ Election Day (November)</td>
<td>☐ President's Day (February)</td>
</tr>
<tr>
<td>☐ Thanksgiving (November)</td>
<td>☐ Columbus Day (October)</td>
</tr>
<tr>
<td>☐ Christmas Day (December)</td>
<td>☐ Easter (March/April)</td>
</tr>
</tbody>
</table>

### Authorization for Emergency Medical Care

I understand that I will be notified at once in case of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize:

- [ ] Day Care Provider or Home Provider

To contact the following:

#### Physician or Clinic

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
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</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

#### Preferred Hospital

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
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<tr>
<td></td>
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</tbody>
</table>

### Acknowledgements

- A. I have received a copy of this facility's policies pertaining to the admission, care and discharge of children.
  - Parent/Guardian Initials

- B. I have been informed that a copy of the licensing rules for child care homes or the licensing rules for group child care centers is available at this facility for review.
  - Parent/Guardian Initials

- C. The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior, and individual needs.
  - Parent/Guardian Initials

- D. When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.
  - Parent/Guardian Initials

- E. I understand that, before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemption from immunizations.
  - Parent/Guardian Initials

- F. I [ ] Do [ ] Do not give permission for field trips/excursions. I understand I will be notified in advance when they are planned.
  - Parent/Guardian Initials

- G. I [ ] Do [ ] Do not give permission for the facility to transport my child.
  - Parent/Guardian Initials

- H. I have been informed and have received a copy of the facility's safe sleep policy when enrolling a child less than one (1) year of age.
  - Parent/Guardian Initials

- I. I have been notified that I may request notice at initial enrollment or any time there after whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.
  - Parent/Guardian Initials

Parent/Guardian's Signature: [ ]

Date: [ ]

### CAFCP Requirement

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Initial Update</th>
<th>Second Update</th>
<th>Third Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Annual</td>
<td>Parent/Guardian Signature</td>
<td>Date</td>
<td>Parent/Guardian Signature</td>
</tr>
</tbody>
</table>
CONSENT & PERMISSION

Child’s Name: __________________________ Date of Birth: ____________

PLEASE NOTE ANY EXCEPTIONS TO THE FOLLOWING CONSENTS & PERMISSIONS

PICTURE RELEASE

Permission is given for pictures including those for identification, emergency use, educational programming and CLC publications such as brochures, fliers, newsletters, public information articles, social media and website.

☐ YES, I give permission for my child’s picture to be taken for uses listed above.

☐ NO, I do not give my permission for my child’s picture to be taken for the uses listed above.

CLC NEWSLETTER

Permission is given to be signed up for CLC’s newsletter.

☐ YES, I would like to receive CLC’s newsletter. Email: __________________________

☐ NO, I would not like to receive CLC’s newsletter.

EXCEPTIONS / RESTRICTIONS TO THE ABOVE INFORMATION:

______________________________

FAMILY HANDBOOK POLICY & PROCEDURES

As a parent or guardian of a child enrolled in the Children’s Learning Center (CLC), I have been explained and received a Family Handbook with information that describes the program and outlines the program’s policies and procedures, including Non-Discrimination and Grievance policies. I understand CLC will follow policies and procedures as outlined in the Family Handbook in regard to my child.

______________________________
Legally Responsible Person’s Signature

______________________________
Relationship

______________________________
Date
Child’s Name | Birth Date | Age

Parent/Guardian Name(s)

How would you describe your child’s personality and learning style?

Is your child using the toilet independently? □ Yes □ No
If not, to what extent does he/she need assistance?

Does your child drink from a sippy or a cup?

Describe your child’s peer relationships:

Please the names and ages of any siblings your child has:

In your opinion, what areas might we be able to give special help and encouragement to your child?

Do you have any concerns about your child? Please state any special services (i.e. speech therapy, occupational therapy, physical therapy, psychological counseling) that your child has received or is still receiving. This information is confidential and is intended to assist the staff in working with your child. Does your child have any allergies, medication, or other health info that you would like to share?

Please list three activities your child enjoys:

What expectations/goals do you have for your child in sending him/her to Children’s Learning Center?

Please use this space if there is any additional information about your child that you would like to share:

Please indicate your preferred method of daily communication by CLC and your teacher:

□ Text □ Email □ Facebook □ Note in Cubby

Email Address:

Phone number(s) for Contact:

Even if you prefer to receive your daily communication in a form other than texting, is it okay to text special communication? □ Yes □ No

Is it okay to send pictures via text that are specific to your child? □ Yes □ No
Child Name:

DOB:

In what county do you reside?

Does your child receive services from therapists?
Yes □ No □
If yes, please list your provider:

Physical Therapist:

Occupational Therapist:

Speech Therapist:

Special Instructor:

Other:

Is your child enrolled in the Missouri First Steps Program?
Yes □ No □
Are you or your child a client of CCDDR? If yes, what is the name of your support coordinator?
Yes □ No □

Is your child on an IEP?
Yes □ No □

Does your child have any special sensory needs? For example, are there any smells, sights, or other senses that are sensitive or need extra attention?

Additional information you would like to provide:
**CLC TUITION**

Please Fill Out Steps 1-4

---

**STEP 1:**

**HALF DAY OPTIONS**

**HALF DAY PREK w/ BREAKFAST**

- **TWO HALF DAYS PER WEEK**
  - $120 MONTHLY  T/R (AM)  7:30AM-11:30AM
  - $145 MONTHLY  T/R (PM)  11:30AM-4:30PM

- **THREE HALF DAYS PER WEEK**
  - $180 MONTHLY  M/W/F (AM)  7:30AM-11:30AM
  - $205 MONTHLY  M/W/F (PM)  11:30AM-4:30PM

- **FOUR HALF DAYS PER WEEK**
  - $240 MONTHLY  M-F (AM)  7:30AM-11:30AM
  - $265 MONTHLY  M-F (PM)  11:30AM-4:30PM

- **FIVE HALF DAYS PER WEEK**
  - $300 MONTHLY  M-F (AM)  7:30AM-11:30AM
  - $325 MONTHLY  M-F (PM)  11:30AM-4:30PM

**OR**

**FULL DAY OPTIONS**

**FULL DAY PREK w/ BREAKFAST, LUNCH, & 1 SNACK**

- **ONE FULL DAY PER WEEK**
  - $120 MONTHLY  7:30AM-4:30PM

- **TWO FULL DAYS PER WEEK**
  - $240 MONTHLY  T/R  7:30AM-4:30PM

- **THREE FULL DAYS PER WEEK**
  - $360 MONTHLY  M/W/F  7:30AM-4:30PM

- **FOUR FULL DAYS PER WEEK**
  - $480 MONTHLY  4 DAYS  7:30AM-4:30PM

- **FIVE FULL DAYS PER WEEK**
  - $600 MONTHLY  M-F  7:30AM-4:30PM

**STEP 2:**

**YEARLY FEE**

- $75 REGISTRATION FEE, PAID YEARLY

**STEP 3:**

**OTHER**

ADDITIONAL NEEDS/NOTES:

---

Parent/Guardian Signature: ____________________  Date: __________

Administrator Signature: ____________________  Date: __________
Dear Family:

Many families of young children have needs for information or support. If you wish, our staff are very willing to discuss these needs with you and work with you to identify resources that may be helpful.

Listed below are some needs commonly expressed by families. Please read each statement and decide if you need help in this area. At the end there is a place for you to describe other topics not included in the list. If you choose to complete this form, the information you provide will be kept confidential. If you would prefer not to complete the survey at this time, you may keep it for your records.

INFORMATION

I need more information about...

☐ How children grow and develop.
☐ How to play with or talk to my child.
☐ How to handle my child’s behavior.
☐ How children with disabilities grow and develop.
☐ Services presently available for my child with special needs.

FAMILY & SOCIAL SUPPORT

I need to have...

☐ Someone I can talk to about concerns or better communication with my spouse.
☐ More opportunities to meet and talk with parents of children like mine.
☐ More time for myself.
☐ More time just to talk with my child’s teacher/therapist.
☐ Help deciding on and doing family recreational activities.

FINANCIAL

I need help...

☐ Paying for expenses such as food, housing, medical care, clothing, or transportation.
☐ Paying for special equipment for my child with special needs.
☐ Paying for therapy, childcare, or other services for my child.
☐ Paying for toys or educational equipment that my child with special needs requires.
☐ Obtaining employment or employment counseling.

COMMUNITY SERVICES

I need help...

☐ Locating a doctor or specialist who understands my child’s needs and me.
☐ Locating a dentist who understands my child’s needs and me.
☐ Finding community recreation for my child.
☐ Locating childcare outside of regular working hours for my child.
☐ Connecting with the local faith community.

EXPLAINING TO OTHERS

I need...

☐ Help in how to explain my child’s difference to siblings, classmates, family members, or community members.
☐ To know where I can sign my other children up for Sibling Workshops/Support Groups.
☐ Information to help my spouse understand and accept our child’s special needs.
☐ Help in knowing how to respond when friends, neighbors, or strangers ask questions about my child’s condition.

CONTINUED ON REVERSE
Family Needs Survey

(continued)

OTHER: Please list other topics or provide any other information that you would like to discuss.

What are your greatest family needs at this time? (These may include needs listed on the survey or other needs):

Is there a particular person with whom you would prefer to meet?

Thank you for your time.

We hope this form will be helpful to you in identifying the services that you feel are important.

Information taken from: Donald B. Bailey, Jr. and Rune J. Shemanoski, FPG Child Development Institute, The University of North Carolina at Chapel Hill
IDENTIFYING INFORMATION

CHILD’S NAME

BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child’s medical history, current state of health and my physical examination of the child on _____/_____/_____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN’S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN

DATE

PHYSICIAN’S OR NURSE’S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP)

IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN’S NAME (PLEASE PRINT)

TELEPHONE NUMBER

TO BE FILED IN CHILD’S RECORD AT CHILD CARE FACILITY
Dear Parent or Legal Guardian:

Our center is currently participating in the Child and Adult Care Food Program. This program reimburses the center for the partial cost of meals provided to children and allows the center to provide nutritious meals without increasing the center's fees to you. If your yearly income is equal to or below the amount listed for your family size on the chart below, your child is eligible for free or reduced-price meals. If the income is higher than the amount listed for your family size, you do not need to complete the income application.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Yearly Income</th>
<th>Family Size</th>
<th>Yearly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$22,459</td>
<td>5</td>
<td>$54,427</td>
</tr>
<tr>
<td>2</td>
<td>$30,451</td>
<td>6</td>
<td>$62,419</td>
</tr>
<tr>
<td>3</td>
<td>$38,443</td>
<td>7</td>
<td>$70,411</td>
</tr>
<tr>
<td>4</td>
<td>$46,435</td>
<td>8</td>
<td>$78,403</td>
</tr>
</tbody>
</table>

For each additional Family Member, add $7,992

To apply for free or reduced-price meal benefits for your children, you must complete the attached Income Eligibility Form (IEF). Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided; however you are not required to complete the IEF. Notify the center should the household income decrease and/or if the household size increases. A participant may be eligible for free or reduced-price meals. The application is valid until the last day of the month in which the form was approved/dated/signed one year earlier.

Sincerely,

Center Owner/Director

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-302) 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:
Parent/Guardian Instructions for Completing the Income Eligibility Form (IEF)

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

- List all children that you are applying to enroll in the child care.
- List each child’s birth date.
- If you are applying for a foster child, the foster child is eligible for free meals regardless of household income, and you do not need to complete the IEF. Talk to the child care center director regarding documentation of a foster child’s eligibility.
- If your child receives Temporary Assistance (formerly AFDC, now funded by TANF) payments or Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps), please indicate the appropriate case number in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete part 2.
- If you have a SNAP or Temporary Assistance case number for at least one of your children enrolled at the center the eligibility extends to all of your children enrolled at the center. You do not need to complete Part 2.
- If you do not participate in SNAP or TANF you must complete all sections of the form including Part 1, 2, 3, 4.

PART 2: HOUSEHOLD AND INCOME INFORMATION – Not completed if case number for SNAP or TANF is provided in Part 1.

- List all members of the household not included in Part 1. A household is a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses).
- Report the monthly income by source for each household member.
- The income reported on the application must include all income before taxes and before other deductions.
- Income Exclusions not to be reported or counted include:
  1. Payments received for the care of foster children.
  2. Student financial assistance provided for the costs of attendance at an educational institution, such as grants and scholarships.
  3. Loans, such as bank or student loans, since these funds are only temporarily available and must be repaid.

PART 3: RACIAL ETHNIC INFORMATION—Completion is Voluntary

PART 4: SIGNATURE

- The adult household member completing the application must sign and date the application.
- If the child(ren) is not a Temporary Assistance or SNAP recipient, the adult signing the application must provide the last four digits of his/her social security number.
- If you do not have a social security number, write "none" in the space provided.
Child and Adult Care Food Program
Income Eligibility Guidance for Child Care Centers

- Failure to provide the last four digits of your social security number, if you have one, will make the income application invalid if the child(ren) is not a SNAP or Temporary Assistance recipient.
- The adult household member completing the IEP must attest to the fact that the information provided is correct, that it is being given in connection with the receipt of federal funds, that it is subject to verification, and that the deliberate misrepresentation of facts will subject the individual to prosecution under applicable state and federal statutes.
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES (MDHSS)
COMMUNITY FOOD AND NUTRITION ASSISTANCE - CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
CACFP ENROLLMENT FORM FOR CHILD CARE CENTERS

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

CHILD'S FULL NAME

DATE OF BIRTH

PARENT OR GUARDIAN NAME

STREET ADDRESS

CITY

STATE

ZIP CODE

DAYTIME PHONE NUMBER

NAME OF CHILD CARE CENTER

PHONE NUMBER

CENTER CONTACT PERSON'S NAME

CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE. (I)

<table>
<thead>
<tr>
<th>WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY?</th>
<th>WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY?</th>
<th>WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MON</td>
<td>AM/PM</td>
<td>AM/PM</td>
</tr>
<tr>
<td>TUES</td>
<td>AM/PM</td>
<td>AM/PM</td>
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<tr>
<td>WED</td>
<td>AM/PM</td>
<td>AM/PM</td>
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<tr>
<td>THURS</td>
<td>AM/PM</td>
<td>AM/PM</td>
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<tr>
<td>FRI</td>
<td>AM/PM</td>
<td>AM/PM</td>
</tr>
<tr>
<td>SAT</td>
<td>AM/PM</td>
<td>AM/PM</td>
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<tr>
<td>SUN</td>
<td>AM/PM</td>
<td>AM/PM</td>
</tr>
</tbody>
</table>

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

☐ FULL DAY CARE
☐ HALF DAY - MORNING
☐ HALF DAY - AFTERNOON
☐ BEFORE SCHOOL CARE
☐ AFTER SCHOOL CARE
☐ BEFORE AND AFTER SCHOOL CARE
☐ EVENING CARE
☐ OVERNIGHT CARE

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

☐ BREAKFAST
☐ LUNCH
☐ AFTERNOON SNACK
☐ SUPPER
☐ EVENING SNACK

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

☐ NEW YEAR'S DAY (JANUARY 1)
☐ MARTIN LUTHER KING'S BIRTHDAY (JANUARY)
☐ PRESIDENT'S DAY (FEBRUARY)
☐ MEMORIAL DAY (MAY)
☐ INDEPENDENCE DAY (JULY 4)
☐ LABOR DAY (SEPTEMBER)
☐ THANKSGIVING DAY (NOVEMBER)
☐ CHRISTMAS DAY (DECEMBER 25)

SIGNATURE OF PARENT OR GUARDIAN

DATE

ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIATED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM.

FIRST ANNUAL UPDATE

PARENT SIGNATURE

DATE

SECOND ANNUAL UPDATE

PARENT SIGNATURE

DATE

THIRD ANNUAL UPDATE

PARENT SIGNATURE

DATE

MO 680-2756 (1-05)

CACP- 229
To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

**PART 1 CHILDREN ENROLLED AT THE CHILD CARE CENTER**

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number for all of the children listed in Part 1.

<table>
<thead>
<tr>
<th>NAME (first and last)</th>
<th>FOSTER CHILD</th>
<th>BIRTH DATE</th>
<th>SNAP CASE NUMBER</th>
<th>TEMPORARY ASSISTANCE CASE NUMBER</th>
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**PART 2 HOUSEHOLD AND INCOME INFORMATION**

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

**INCOME BASED ON (CHECK ONE)**

YEARLY [ ] MONTHLY [ ] 2X A MONTH [ ] EVERY 2 WEEKS [ ] WEEKLY [ ]

<table>
<thead>
<tr>
<th>HOUSEHOLD MEMBERS</th>
<th>GROSS WAGES</th>
<th>WELFARE, CHILD SUPPORT, ALIMONY</th>
<th>PENSIONS, RETIREMENT, SOCIAL SECURITY</th>
<th>OTHER</th>
</tr>
</thead>
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**PART 3 RACIAL ETHNIC INFORMATION** (You are not required to answer this section)

Are you of Hispanic or Latino origin? [ ] YES [ ] NO

What is your race? (Select one or more)

- AMERICAN INDIAN OR ALASKA NATIVE [ ]
- ASIAN [ ]
- BLACK OR AFRICAN AMERICAN [ ]
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER [ ]
- WHITE [ ]

**PART 4 SIGNATURE**

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER: [ ]

SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY): [ ]

DATE: [ ]

PRINTED NAME OF ADULT: [ ]

ADDRESS: [ ]

PHONE NUMBER: [ ]

Section 9 of the National School Lunch Act requires that, unless your child's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household members in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

**FOR CENTER USE ONLY**

TOTAL HOUSEHOLD SIZE: [ ]

INCOME: [ ]

INCOME BASED ON (CHECK ONE):

- YEAR [ ]
- MONTH [ ]
- 2X A MONTH [ ]
- EVERY 2 WEEKS [ ]
- WEEKLY [ ]
- SNAP (Food Stamp) [ ]
- TEMPORARY ASSISTANCE [ ]

Eligibility Determination: [ ] Free [ ] Reduced [ ] Paid

SIGNATURE OF CENTER REPRESENTATIVE: [ ]

DATE: [ ]

MO 5401-1314 (2-11)
CLC
2018-2019
School Supply List

Classroom Supplies

- 2 packs of glue sticks
- 2 packages of thermal laminating pouches (8.5x11)
  - 4 boxes of tissues
- 4 rolls of paper towels
- 1 box sandwich size baggies
- 1 box gallon size baggies
- 1 pack of unscented baby wipes
- 1 pack of sidewalk chalk
- 1 large assortment of fuzzy sticks (pipe cleaners) OR pom-poms

*Throughout the year, we may ask for help to replenish these items.

Personal Supplies

- Antibiotic ointment (if needed)
  - Sunscreen
  - Baby wipes (if needed)
- Diaper ointment (if needed)
- Diapers or pull-ups (if needed)

- 2 sets of extra clothes (pants/shorts, shirts, socks, underwear)
  - Blanket