July 19, 2023

Dear Parent,

Please complete the attached annual update for your child's enrollment at our center and the USDA food program.

If you have difficulty completing these forms electronically, please ask your child's teacher for paper forms.

Please complete the forms and either upload in the Procare application, or give to your child's teacher no later than August 31st.

We appreciate your cooperation, and confidence in caring for your child.

Thank you,

Stephanie Campbell, Director

828-342-7737

Date Update Completed: ________________

CHILDREN'S ANNUAL UPDATE FOR CHILDCARE

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually

CHILD INFORMATION: Date of Birth: ____________________

Full Name:____
Last First Middle Nickname

Child's Physical Address:____

FAMILY INFORMATION: Child lives with: ____

Father/Guardian's Name____Home Phone____________________

Address (if different from child's)____Zip Code __________________

Work Phone____Cell Phone________________________

Mother/Guardian's Name____Home Phone____________________

Address (if different from child's)____Zip Code __________________

Work Phone____Cell Phone________________________

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a Medical action plan attached? Yes __ No __ (Medical action plan must be updated on an annual basis and when changes to the plan occur)

List any allergies and the symptoms and type of response required for allergic reactions.________________________________

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns ___________

List any particular fears or unique behavior characteristics the child has____

List any types of medication taken for health care needs____

Share any other information that has a direct bearing on assuring safe medical treatment for your child_______________________

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional ____Office Phone________________

Hospital preference ____Phone ____________________

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian____Date_______________

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator____Date_______________

INSTRUCTIONS
Please complete the Infant and Child Income Eligibility Applications using the instructions below. The application must be signed in number 6 and returned to the child care center.

1-PARTICIPANT'S INFORMATION:

a. Print the name(s) and birth date(s) of the infant(s) and/or child/children enrolled in the center.

2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS:

a. If you participate in SNAP, TANF, or FDPIR provide your case or identification number and skip number 4.
b. If you do not participate in any of these programs, go on to number 3.

3-FOSTER, HOMELESS, or MIGRANT INFANT/CHILD:

a. Indicate if either infant/child on the application is a foster infant/child, homeless, or an infant/child from a migrant family.
b. Households with foster and non-foster infants/children may choose to include the foster infant/child as a household member, as well as any personal income earned by the foster infant/child, on the same household application that includes their non-foster infants/children.
c. Host families applying for free and reduced priced meals for their own infants/children may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.
d. If the infant(s) and/or child/children listed are foster, homeless, or from a migrant family, number 4 may be skipped.

4- HOUSEHOLD INCOME:

a. List the names of all other household members.
b. Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **last month** for each household member and where it came from, such as earnings, public assistance, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person's usual income.

INCOME TO REPORT

Earnings from Employment	Pensions/Retirement/Social Security	Other Income
• Wage/salaries/tips • Strike benefits • Unemployment compensation • Net income from self-owned business or farm • Worker's compensation Public Assistance/Child Support/Alimony • Public assistance payments • TANF payments • Alimony/Child support payments	• Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security Military Households • All cash income, including military benefits received in cash such housing/uniform allowances.	• Disability benefits • Cash withdrawn from savings • Interest/dividends • Income from estates/trusts/ investments • Regular contributions from persons not living in the household • Net royalties/annuities/ net rental income • Any other income

5-RACIAL/ETHNIC IDENTITY: Complete the Ethnic/Racial identity question.

6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this part.

All Infant and Child Income Eligibility Applications must be signed by an adult household member.
If qualifying by income, the adult household member who signs the certification statement must include the last four digits of his/her social security number. If he/she does not have a social security number, check the "No SSN" box. If the participant is a foster infant/child, homeless, or infant/child from a migrant family and/or listed a SNAP, TANF, or FDPIR number a social security number is not needed.

 This institution is an equal opportunity provider.

HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS

Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of program Income Eligibility Applications. This application will be used only for eligibility determination, placed in our files, and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the program Income Eligibility Application (IEA) for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced-price participant.

If you currently receive SNAP, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your SNAP, TANF or FDPIR case number, sign, date and return the application. If an infant and/or child is a member of a SNAP or FDPIR household or is a TANF recipient, the infant/child is automatically eligible to receive free program meal benefits, subject to completion of the application.

You should also note that if you have a foster infant/child the day care center is eligible for program benefits for the foster infant/child regardless of the income of your household. Households with foster and non-foster infants/children may choose to include the foster infant/child as a household member, as well as any personal income earned by the foster infant/child, on the same household application that includes their non-foster infants/children. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all infants, children, parents, grandparents, and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income reported **must** be the total gross income, before deductions, received by all members of the household last month (i.e. wages, public assistance, TANF or retirement, etc.). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance **must** be considered as income. If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

REDUCED GUIDELINES EFFECTIVE JULY 1, 2023 - JUNE 30, 2024*

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	$26,973	$2,248	$1,124	$1,038	$519
2	$36,482	$3,041	$1,521	$1,404	$702
3	$45,991	$3,833	$1,917	$1,769	$885
4	$55,500	$4,625	$2,313	$2,135	$1,068
5	$65,009	$5,418	$2,709	$2,501	$1,251
6	$74,518	$6,210	$3,105	$2,867	$1,434
7	$84,027	$7,003	$3,502	$3,232	$1,616
8	$93,536	$7,795	$3,898	$3,598	$1,799
For each additional family member add:	$9,509	$793	$397	$366	$183

*Households with income less than or equal to these levels are eligible for free or reduced-price meals.

You may submit an Infant and Child Income Eligibility Application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

This institution is an equal opportunity provider.

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

INFANT AND CHILD INCOME ELIGIBILITY APPLICATION

INSTITUTION NAME:______________________________________ FACILITY NAME:_________________________________ AGREEMENT#: ______________

1. PARTICIPANT'S NAME & DATE OF BIRTH:

____ ____

First Name Last Name Date of Birth First Name Last Name Date of Birth

2. SNAP, TANF or FDPIR case number:

SNAP #____________________________ **TANF#:** ______________________________ **FDPIR #** ___________________________

If you have provided the case number; DO NOT complete #3 and #4. **Skip to complete #5 and #6**.

3. Is this application for a:

Foster Infant/Child? ☐ Yes ☐ No Homeless Infant/Child? ☐ Yes ☐ No Infant/Child from a migrant family? ☐ Yes ☐ No

4. HOUSEHOLD MEMBERS MONTHLY INCOME:

Names of All Other Household Members	Monthly Wages / Salaries	Monthly Social Security	Monthly Public Assistance / Child Support	Monthly Retirement Pensions	Other Monthly Income
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

5. ETHNIC IDENTITY: (Check one). ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

6. **SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:** I certify that all of the above information is true and correct; that the application is being made in connection with the receipt of federal funds, that Program officials may verify the information on the application; and that deliberate misrepresentation of any of the information on the application may subject me to prosecution under applicable State and Federal criminal statutes.

____ Check if no SSN ☐ ________________________

Signature of Adult Household Member (Required) Date

Last Four Digits of Social Security Number
(Required **only** if qualifying by income**)**

____ ____

Printed Name Home Telephone # Work Telephone #

____

Address City Zip Code

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 your infant/child for free or reduced-price meals. You must include the last four digits of the social security number or check the "no SSN" box of the adult household member who signs the application if qualifying by income. The last four digits of the social security number is not required when you apply on behalf of a foster infant/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 your infant/child 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 your infant/child is eligible for free or reduced-price meals and for administration and enforcement of the Program.

To be completed by Institution/Sponsor

TOTAL HOUSEHOLD SIZE _______TOTAL HOUSEHOLD MONTHLY INCOME $ _____________

Approved: ☐ Free ☐ Reduced-Price ☐ Denied

Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other: __________________

Withdrew on (Date): ______________________

For state use only:
Verified by: _________________Date:__________
Verified classification:
☐Free ☐Reduced-Price ☐Denied
Reason for classification change:______________
____

____

Signature of Eligibility Official (Individual at the Institution Level) – Required **Date – Required**

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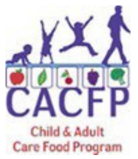
North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program



Infant and Child Enrollment Form 2024

INSTITUTION NAME:________________________ FACILITY NAME:________________________ AGREEMENT#: ____________

Dear Parent/Guardian,
This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program. Be sure to sign and date in the space below.

The information below must be completed by the parent or guardian.

Infant/Child's First Name	Infant/Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			7:30A to 4:30P	M T W Th F Sat Sun	B AM L PM S LPM
			7:30 A to 4:30P	M T W Th F Sat Sun	B AM L PM S LPM
			7:30 A to 4:30P	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM

Normal/Typical Hours of Care: Write in each infant/child's usual arrival and departure time. Indicate a.m. or p.m.
Normal Days of Care: Circle the days of the week each infant/child is usually in attendance at the facility.
(M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)
Meals Normally Eaten – Circle the meals each infant/child usually eats at the facility.
(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature:______________________________ **Date:** ____________

Print Name: ______________________________

Address: ____

City:______________________________State: NC ______Zip Code: __________

Home Telephone Number: ( )________________Work Telephone Number: ( ) ________________

For Facility/Provider Use Only:
Signature of Facility Representative/Provider:________________________________Date: ____________
Date each infant/child withdrew:____

For State Use Only: Complete:_______Incomplete________ Reason:__________________________ Verified by:________________Date:__________

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