Pennsylvania Pre-K Counts Program

Dear Parent:

Thank you for your interest in the Pennsylvania Pre-K Counts Program!

Enclosed please find a Pennsylvania Pre-K Counts Application, Child Health History Form, child health assessment forms, and return envelope. Eligible children will be accepted into this program on a first-come, first-served basis for the 2016-2017 program year with preference given to children who will enter Kindergarten in the 2017-2018 school year. Please complete and return the following information in order to be considered for this program:

1) A **completed** Pennsylvania Pre-K Counts Application;
2) A **completed** Child Health History Form;
3) **Proof of residence** (This could be a utility bill, address on a bank statement, or anything else showing your current address);
4) A **copy** of your child's birth certificate or record;
5) A **copy of verification of income** (preferred documentation is a copy of your 2015 Tax Return Form 1040);

**** In order to qualify your total household income must be within the following income guidelines:**

Family Size	Gross Annual Income	Family Size	Gross Annual Income
1	$35,640	**5**	$85,320
2	$48,060	**6**	$97,740
3	$60,480	**7**	$110,190
4	$72,900	**8**	$122,670
Each Add'l	**$12,480**		

6) If a **TANF** recipient please include **county case message**, TANF printout, proof of SSI or foster care letter;
7) **Completed physical and immunization forms with dental records**.

- **The immunization form, physical, dental, proof of residence, birth certificate, and income verification must be returned with the application ASAP in order to process the application for possible selection into the Pre-K Counts Program.**
- The Pre-K Counts Program runs a full school year, Monday-Thursday 8:30am- 2:30pm and Friday 8:30am-12:00pm. Breakfast, lunch and snack are provided.
- There is an **attendance policy** that requires a **minimum** of 85% attendance per month. If this is not met, your child may be removed from the program.

When your child is awarded enrollment, you will receive notification by mail or phone call. Please mail the above-mentioned information to:

Allegheny Intermediate Unit
Attn: Krista Molnar
Pre-K Counts, 3rd Floor
475 East Waterfront Drive
Homestead, PA 15120

Should you have questions, please call the Pennsylvania Pre-K Counts enrollment line at 412-394-5863. Someone will respond to your call as soon as possible..

AIU EARLY CHILDHOOD EDUCATION
HEAD START& PRE-K COUNTS APPLICATION 2016-2017

Eligible Child Information

Child's Legal Name: (from Birth Certificate, Green Card or I-94) _____ **ID:** _____

Application Date: _____ **Birth Date:** _____

Gender: _____

Ethnicity: _____ **Latino:** ☐ Yes ☐ No

Primary Language: _____ **Other Language:** _____

Non-English Speaking: _____ **Relationship to Primary Caregiver:** _____

Active IEP or IFSP: ☐ Yes ☐ No **Child has received services at other preschool:** ☐ Yes ☐ No **Site Name:** _____

Child was referred to program: ☐ Yes ☐ No **If Yes, please list referring agency:** _____

Comments:

Program Information

Desired Center 1st Choice: **Desired Center 2nd Choice:**

Primary Caregiver General Information

Name (first/mi/last): _____ **Birth Date:** _____

Gender: _____

Ethnicity: _____ **Latino:** _____

Education Level : _____ **Employment Status:** _____

Primary Language: _____ **Disabled:** _____

Phone (home): _____ **Phone (cell):** _____ **Phone (work) :** _____

Address: _____ **E-mail Address:** _____

City: _____ **School District of Residence:** _____

State: PA **Zip Code:** _____

 # in Family: _____ **# in Household:** _____

Staff Completing Paperwork: _____ **Family in transition within the past 12 months:** _____

Family Advocate: _____ **Household Type:** _____

Are you staying in a permanent or temporary living arrangement: _____ **Are you staying with friends/relatives for just a little while:** ☐ Yes ☐ No

Do you stay in the same place every night: ☐ Yes ☐ No **Does the place where you stay have heat/electricity/running water?** ☐ Yes ☐ No

Is there shared custody of eligible child with any other individual? ☐ Yes ☐ No

Comments:

Secondary Caregiver General Information ☐ REFUSED ☐ DECEASED ☐ NO SECONDARY CAREGIVER

Name (first/mi/last): _____ **Birth Date:** _____

Gender: _____

Ethnicity: _____ **Latino:** _____

Education Level : _____ **Employment Status:** _____

Primary Language: _____ **Disabled:** _____

Phone(home): _____ **Phone(cell):** _____ **Phone (work) :** _____

Address: ☐ Same as Primary Caregiver ☐ Unknown _____

City: _____

State: _____ **Zip Code:** _____ **Relationship to Eligible Child:** _____

Does Family Receive any of the following? *(mark all that apply):* ☐ NO SERVICES RECEIVED

☐ **TANF-CASH**	☐ **TANF-Food Stamps**	☐ **WIC**
☐ **TANF-Child Care Subsidy**	☐ **TANF-Medical Assistance**	☐ **Energy Program Assistance**
☐ **TANF-Job Training Program**	☐ **Unemployment**	☐ **Subsidized Housing**
☐ **Foster Child**	☐ **SSI (Immediate Family Member(s) ONLY)**	

Child Emergency Information (PLEASE do not use Primary and Secondary Caregiver(s))

First Name	Last Name	Home Phone	Cell Phone	Language Spoken	Release To	Emergency Contact
					☐	☐
					☐	☐
					☐	☐

Head Start and Pre-K Counts Application 16-17

Child's Legal Name: (from Birth Certificate, Green Card or I-94) ______________ Birth Date: __________ Classroom: ______________

Misc Information for PIR

- ☐ **Child needs full-year day care**
- ☐ **Child needs full-day day care**
- ☐ **Child has secondary source of child care**
- **Type of secondary child care:**
- ☐ **Child is receiving a childcare subsidy (Voucher or Contracted slot)**
- ☐ **Father/father figure participates in regularly scheduled activities designed for involvement in HS**

☐ **NO OTHER HOUSEHOLD MEMBERS** **(Continue to page 3)**

Household Information (include ALL children and adults in the household EXCEPT Primary and Secondary Caregiver)

Full Name:		**Gender:**	
Date of Birth:		**Disabled:**	
Ethnicity:		**Relation to Eligible Child:**	
Full Name:		**Gender:**	
Date of Birth:		**Disabled:**	
Ethnicity:		**Relation to Eligible Child:**	
Full Name:		**Gender:**	
Date of Birth:		**Disabled:**	
Ethnicity:		**Relation to Eligible Child:**	
Full Name:		**Gender:**	
Date of Birth:		**Disabled:**	
Ethnicity:		**Relation to Eligible Child:**	
Full Name:		**Gender:**	
Date of Birth:		**Disabled:**	
Ethnicity:		**Relation to Eligible Child:**	
Full Name:		**Gender:**	
Date of Birth:		**Disabled:**	
Ethnicity:		**Relation to Eligible Child:**	
Full Name:		**Gender:**	
Date of Birth:		**Disabled:**	
Ethnicity:		**Relation to Eligible Child:**	

I declare under penalty of perjury and the laws of the State of Pennsylvania that the information and income contained herein is true and correct to the best of my knowledge. If any part is false, my participation in this agency's program(s) may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

I certify that I have examined the above income documentation.

Primary Caregiver's Signature ______________

Date Signed: ______________

Staff Signature ______________

Date Signed: ______________

Allegheny Intermediate Unit

Dear Parent/Guardian:

Head Start is mandated by the Federal Government to be in compliance with the PA EPSDT schedule that is included on this physical assessment form. Please talk with your physician and request that he/she document all information.

Head Start children are required to have proof of lead and hemoglobin screenings that should have been done at the 9-11 month checkup. Please ask for those original DATES and VALUES and/or the most recent results.

Please speak with your pediatrician and explain that all of the information on the physical health assessment form needs to be filled out completely before you leave the office.

Thank you so much for your help.

Cynthia M. Callaghan, CRNP
Service Coordinator for Physical Health
412/394-3616

Chris D. Rodgick
AIU-3 Head Start Director

Exam Date_____

Allegheny Intermediate Unit

Head Start/Pre-K Counts Child Physical Assessment Form

Provider Please Note: **Federal and Head Start guidelines *REQUIRE* this information. It is very important that *ALL* *HIGHLIGHTED* areas of this form are filled out completely. This includes lead and hemoglobin values/ dates.**

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

Hgb: _____ _____ Value Date	**Hct:** _____ _____ Value Date	**Lead:** _____ _____ Value Date
Ht: _____ _____ Inches date **Wt:** _____ _____ lbs. date	**If the child is over/ underweight or obese, is there a treatment plan? ____Yes ____No**	

Area Examined	Finding
General Appearance	___ normal ___abnormal ___not examined
Head	___ normal ___abnormal ___not examined
Nose	___ normal ___abnormal ___not examined
Teeth	___ normal ___abnormal ___not examined
Speech	___ normal ___abnormal ___not examined
Glands	___ normal ___abnormal ___not examined
Lungs	___ normal ___abnormal ___not examined
Heart	___ normal ___abnormal ___not examined
Abdomen	___ normal ___abnormal ___not examined
Skin	___ normal ___abnormal ___not examined
Bones/ joints/ muscles	___ normal ___abnormal ___not examined
Back	___ normal ___abnormal ___not examined
Posture/gait	___ normal ___abnormal ___not examined
Genitalia	___ normal ___abnormal ___not examined
Other/ special needs/ medical care:	Please explain and attach additional information if necessary:

Is this exam part of a well baby exam? _____yes _____no _____(date of exam)
Does this child have any allergies? _____yes _____no. If yes, please describe below: _____

_____

Is this child receiving treatment for diabetes or asthma? ____yes ____no
If this child has received the following screenings, please provide the most recent results:

- **Visual Acuity Screen: _____ left eye _____right eye _____ date**
  Have corrective lenses been prescribed for this child? ____yes ____no
- **Hearing Screen: _____ left ear _____right ear _____date**

Provider Signature: _____ _____ **Title and license #:** _____

Address: _____ _____

Phone #:_____ **Fax #:**_____

Please fill in the immunization information on the reverse side or provide a copy of this child's immunization record with this exam

***PARENT*: I give the Head Start staff permission to speak to my child's healthcare provider**

_____ _____ _____
Parent name (print) **Parent Signature** **Date (of parent signature)**

Child's Name: _____

Date of Birth:_____

Please fill in or attach a copy of the immunization record.

Immunization	date	date	date	date	date	date
DTa/DTP/Td						
Polio						
HIB						
Hep B						
MMR						
Varicella						
Pneumoccal						
Seasonal Flu						
other						

If the child is not up to date with their immunizations, is there a plan in place to bring them up to date? ____Y _____N. If yes, what is the time frame? _____.

Physician/Provider Signature _____

Revised 3/3/15

Allegheny Intermediate Unit

SERVICES, RESOURCES, AND RESEARCH FOR EDUCATION

CHILD'S NAME _____ DOB:_____

Dear Healthcare Provider:

The AIU3 Head Start Child Physical Assessment form has been designed to capture all of the health monitoring information which is <u>required</u> of Head Start by the Federal Government. We are mandated to be in compliance with the PA EPSDT schedule.

Please fill out this form <u>completely</u>.

By providing the information sought on this form, your patient will have the records needed for free high quality early childhood education.

Please include ALL dates and values for the following. If a lead screening was never completed, please test or give the parent a lab order form.

Hemoglobin/Hematocrit	Date	Value
Blood Lead Level	Date	Value
Vision	Date	Result Left Right
Hearing	Date	Result Left Right

_____ Child has no need for lead testing based on physical/verbal assessment. _____
Physician's initials

Physician's Name_____ Date_____

Physician's Signature _____

Thank you so much for your help.

Cynthia M. Callaghan, CRNP
Service Coordinator for Physical Health
412/394-3616

Chris D. Rodgick
AIU-3 Head Start Director

AIU Early Childhood Education/ Early Head Start, Head Start & Pre-K CountsChild Health History

Child Health History

Child's Legal Name: (from Birth Certificate, Green Card or I94)		Birth Date: (MM/DD/YYYY)		Gender:	

Preliminary Questions

1. Will medication be needed at school? ☐ Yes ☐ No
   If yes, please review the policy and procedure for medication administration in the classroom. Please note, a parent permission form must be signed in order for medicine to be administered in the Head Start classroom.
2. Does your child have a prescription for an EPI pen? ☐ Yes ☐ No

Has this child ever had the following illnesses? If so, please give date and explain below

Seizures	☐	Urinary/Kidney Problems	☐	Heart Problems	☐
Bee Sting Allergy	☐	Insulin Dependent Diabetes	☐	Pneumonia	☐
Latex Allergy	☐	Type 2 Diabetes	☐	Asthma	☐
Immune Problems	☐	Chemotherapy/Cancer or Tumor(s)	☐	Anemia (includes sickle cell disease)	☐
Eye Problems (EHS)	☐	Ears/Nose/Throat Problems (EHS)	☐	Food Allergies	☐
Any Additional Health Information:					

Has your child ever had the following? If yes, please give date and explain.

Hospitalizations	☐ Yes ☐ No	
Serious Injuries	☐ Yes ☐ No	
Operations	☐ Yes ☐ No	
Other Health Problems/Illnesses	☐ Yes ☐ No	
Allergies to Medications (i.e. penicillin, sulfa drugs)	☐ Yes (If Yes, please list below) ☐ No	

Immunization History

* Child has received **NO** immunizations: ☐	**All children are required to have proof of immunization status unless exempted for religious, personal beliefs, homelessness or medical contradictions.** (A letter from the parent or a physician is required for exemption).
EHS	Child has received **NO** immunizations: **(EHS)** ☐ Child is up-to-date on all immunizations appropriate for his/her age: **(EHS)** ☐ None of the above: **(EHS)** ☐
	Explain/Comments:

Dental Information

Do you have dental insurance?	☐ Yes ☐ No	Does the child have an Ongoing Source of Continuous and Accessible Dental Care? ☐ Yes ☐ No	
Child has a ***current*** dental exam (within the past year)			☐ Yes ☐ No
Dentist Name		Date of last visit	
Dentist Address		Dentist Phone #	

Were there any dental problems that need follow-up? ☐ Yes ☐ No Comments:

Behavioral Health Information

Do you have any concerns about your child's behavior? ☐ Yes ☐ No	Where?: ☐ At Home	☐ At School	☐ In Public	
Has your child been evaluated or received a behavioral health diagnosis?	☐ Yes ☐ No			
Would you like to be contacted by a Behavioral Health Specialist?	☐ Yes ☐ No			
Comments:				

Health History

Child's Legal Name:
(from Birth Certificate, Green Card or I94) _____ Birth Date: _____ Site: _____

Nutrition Assessment

Does your child's weight appear normal?	☐ Yes ☐ No	Does your child eat fruits and vegetables?	☐ Yes ☐ No
Is your child a picky eater now?	☐ Yes ☐ No	In the past six months, was your child found to be anemic (low blood iron)?	☐ Yes ☐ No
Is your child involved in active play daily?	☐ Yes ☐ No	Does your child have diarrhea frequently?	☐ Yes ☐ No
Does your child have constipation frequently?	☐ Yes ☐ No	Does your child vomit frequently?	☐ Yes ☐ No
Does your child drink from a baby bottle now?	☐ Yes ☐ No	Do you have concerns about your child's growth, nutrition or eating?	☐ Yes ☐ No
Does your child have difficulty chewing or swallowing now?	☐ Yes ☐ No	Please list foods that cause allergic reaction and disclose the reaction:	
Does your child have an allergic reaction to any foods?	☐ Yes ☐ No		

Food Substitution

1.	Is your child restricted from foods due to religious, vegetarian, medical or personal beliefs?	☐ Yes ☐ No
	If yes, please list all that apply:	
2.	**Does your child have any food intolerances (such as lactose intolerance)?** ☐ Yes ☐ No (**If yes**, please list all that apply in the space below)	
3.	What kind of reaction does your child have when your child eats the specified food? (please list reaction(s) below):	
4.	Is your child on any special diet prescribed by a doctor? ☐ Yes ☐ No (If yes, please specify below and ***provide written prescription and list of food substitutions from the physician***.)	
	NOTE TO STAFF - If yes to questions 2, 3, and / or 4 above: - Parent must give physician's prescription to staff prior to selection for placement. **Note: substitutions for non-medical reasons (i.e. religious, vegetarian, etc.) will be reviewed on a case-by-case basis with the Health Services Coordinator. Substitutions for medical reasons require a signed statement from a licensed physician or other medical authority along with a list of substitutions.**	

Asthma/ Allergy Screening

1.	Has your child ever been diagnosed by a medical professional as having asthma? ☐ Yes ☐ No (if no, please go to question #4)	
2.	a. Has your child been hospitalized due to asthma? ☐ Yes ☐ No b. Need for medication (inhaled or oral) to help breathing? ☐ Yes ☐ No	
3.	**Have you ever given your child any medications for asthma?** ☐ Yes ☐ No If yes, please list all medication that your child has **used in the last year**:	
4.	Does anyone in the household smoke? (i.e. home/car) ☐ Yes ☐ No	
	Comments:	

Medical Coverage

	Child Receives Medical Services Through Ongoing source of Continuous, Accessible Medical Care	☐ Yes ☐ No
	Child has a ***current*** physical exam (within the past year)	☐ Yes ☐ No
1.	Does your ***family*** have a regular doctor or a regular place to receive health services?	☐ Yes ☐ No
	Doctor's Name:	
	Doctor's Address:	
	Doctor's Phone #:	Doctor's Fax #:

2. Type of Health Insurance:

☐ Eligible Child Has **NO** Health Insurance

☐ State-Only Funded Insurance (SSI)

Public Assistance (please check one) ☐ Gateway ☐ United ☐ UPMC ☐ AETNA

☐ Private Insurance Company (name of insurance provider) _____ Child's M.A. Number _____

☐ State Child Health Insurance Program (CHIP/SCHIP)

☐ Other (please list insurance type) _____

EHS

Do you use the Allegheny County Health Department Services? ☐ Yes ☐ No If yes what city? _____

Do you have Healthy Families State Child Health Insurance Program? ☐ Yes ☐ No

AIU Early Childhood Education/ Early Head Start, Head Start & Pre-K Counts Consents and Releases

Child's Legal Name:
(from Birth Certificate, Green Card or I94) _____ Birth Date: _____ Site: _____

Screening Permissions		
1.	Developmental screening (to assess levels in language, thinking and problem solving, small motor, gross motor, personal/social skills).	☐ Yes ☐ No
2.	Speech and language screenings (to detect problems with speaking and understanding).	☐ Yes ☐ No
3.	Auditory/Hearing screening (to detect problems with the ears).	☐ Yes ☐ No
4.	Vision screening (to detect problems with vision).	☐ Yes ☐ No
5.	Heights & Weights	☐ Yes ☐ No
6.	Behavioral/Social/Emotional screening (to further assess social and emotional development).	☐ Yes ☐ No
7.	Hemoglobin Testing	☐ Yes ☐ No

Program Consent		
1.	I authorize the staff and my child's dental professional to communicate directly, if needed, to clarify information concerning my child's dental status and releasing the most recent exam.	☐ Yes ☐ No
2.	I authorize the staff and my child's medical professional to communicate directly, if needed, to clarify information concerning my child's health status and releasing the most recent exam.	☐ Yes ☐ No
3.	I give consent for my child to participate in walking trips in the community.	☐ Yes ☐ No
4.	I give consent for my child's image (audio, video, photo) to be captured and used for educational purposes by the Allegheny Intermediate Unit.	☐ Yes ☐ No

Acknowlegement

I have read and understand the Notice of Privacy Practices for Head Start. This notice describes how medical information may be used and disclosed and how I can get access to this information. ☐ Yes ☐ No

In cases of emergency medical/ dental care, Allegheny Intermediate Unit staff WILL secure needed emergency medical care if parents/ guardian cannot be immediately contacted.

Comments:

Kindergarten Transition Release of Information

For the purpose of *KINDERGARTEN TRANSITION*, I consent to release the following information to my child's kindergarten placement: name, date of birth, address, assessments, physical, dental and behavioral health information, including anecdotal information through written and verbal communication.

☐ Yes ☐ No

Release of Information

I authorize permission to share information between the AIU Head Start/ Early Head Start/ Pre-K Counts Program(s) and the following programs/ agencies:

☐ DART Program ☐ Early Head Start ☐ Head Start ☐ Family Centers ☐ Fatherhood ☐ Pre-K Counts ☐ ELECT
☐ Homeless Children's Initiative ☐ Allegheny County Health Dept ☐ Contracted Providers

for the purpose of completing my child's files and interagency collaboration.

_____ _____
Primary Caregiver's Signature **Date (MM/DD/YYYY)**

_____ _____
Staff's Signature **Date (MM/DD/YYYY)**

ECE/Pre-K Counts Child Oral Health Assessment

Date of Exam: ____/____/_____ **Name:** _____

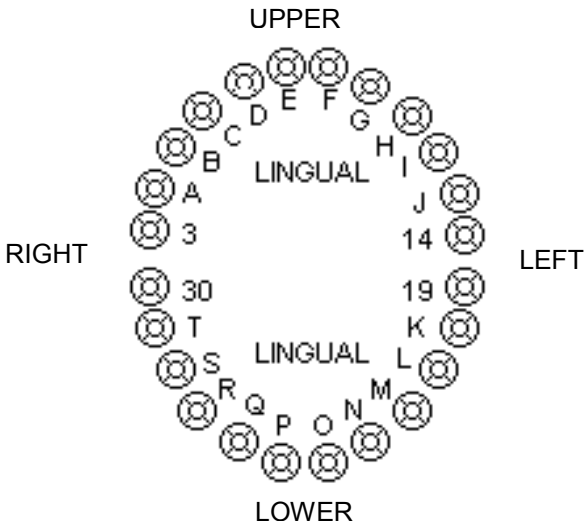
Completed By: ☐ Head Start Staff Name :_____

☐ Dental Provider Name: _____

Provider Setting: ☐ Home ☐ Dental Office/Clinic ☐ School/Center
☐ Employment ☐ Other: Specify _____

Evaluation Type: ☐ Screening ☐ Assessment

ORAL CONDITION



Key: Missing Decayed Filled

Comments:

Number of times per day child brushes teeth: |__|__| Flossing frequency ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Gum Condition:
☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Received Fluoride Treatment? ☐ Yes ☐ No Received Cleaning? ☐ Yes ☐ No

Dental Needs:
☐ No Needs ☐ Treatment ☐ Cleaning
☐ Fluoride Supplement ☐ Oral Hygiene Instruction
☐ Other: Specify _____

Provider Signature: _____ Date: _____

Provider Address: _____ Phone: _____

*** Please use back of form for general comments.**

Child and Adult Care Food Program
Child Enrollment Form

Enrollment Date:

Child _____
Address _____
_____
Birth date _____

Parent/Guardian _____
Address _____
_____
Telephone (home)_____(work)_____

Sponsoring Organization Allegheny Intermediate Unit #3
Address 475 East Waterfront Drive
Homestead, PA 15120

Center/Home _____
Address _____
_____

Normal Hours of Care*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start: 8:30 a.m. End: 2:30 p.m.	Start: 8:30 a.m. End: 2:30 p.m.	Start: 8:30 a.m. End: 2:30 p.m.	Start: 8:30 a.m. End: 2:30 p.m.	Start: 8:30 a.m. End: 2:30 p.m.	Start: End: N/A	Start:. End: N/A

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

Daily Expected Meal Service Participation (please check box)

Breakfast	AM Snack	Lunch	PM Snack	Supper	Eve Snack
x		x	x		

Is this child of school age? ___Yes ___No If yes, will additional meals be provided when school is not in session? ___Yes ___No If yes, please specify the meal: ___Breakfast ___Lunch ___Snack ___Supper

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

_____Day _____Evening _____Time

_____Letter _____Telephone (home) _____Telephone (work)

Signature _____ **Date** _____
Parent/Guardian

Signature _____ **Date** _____
Center Administrator/Home Provider

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

For Sponsor Use Only

Child withdrew on _____

Allegheny Intermediate Unit Head Start & Pre-K Counts Programs

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **AIU3** 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 your child's teacher, ASAP.**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) 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, 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, or 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.

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, please ask your child's teacher.

Sincerely,

Allegheny Intermediate Unit 3
Head Start & Pre-K Counts Programs

Instructions For Completing the CACFP
Child Care Center Meal Benefit Income Eligibility Form

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the case number for any household members (including adults) receiving **State SNAP** or **State TANF** or **FDPIR** benefits.
Part 3: 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.

FOSTER CHILDREN HOUSEHOLDS, will follow these instructions:

A Meal Benefit Form is not required to be completed.

OR

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. 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 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. For ONLY the self-employed, report income after expenses in Box 1. 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 she/he doesn't have one.

Part 6: Answer this question if you choose.

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: 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 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. For ONLY the self-employed, report income after expenses in Box 1. 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 she/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.

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Names of Enrolled Child(ren) (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
	☐	☐
	☐	☐
	☐	☐
Names of all Household Members (First, Middle Initial, Last)		
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF 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.
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 3 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: _____ City:_____ State: _____ Zip Code: _____

Phone Number: _____

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

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

Mark one ethnic identity:

❑ Hispanic or Latino
❑ Not Hispanic or Latino

Mark one or more racial identities:

❑ 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 (Paid)_____ Date Withdrawn: _____

Reason for Denied: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up 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.

Household size	Yearly
1	$20,665
2	$27,991
3	$35,317
4	$42,643
5	$49,969
6	$57,295
7	$64,621
8	$71,947
Each additional person:	+$7,326

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: This explains what to do if you believe you have been treated unfairly. “In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.”