

Abundance of Joy Child Development Center

New Child Information Sheet

Start Date:

Hello, My Name is:

My Nickname is:

Date of Birth:

Parent's Name(s):

Likes:

Dislikes:

Allergies:

Has Your Child Attended Preschool or Child Care Before?

What Kind of Experience Was it?

Days and Times Your Child Will Be Attending Abundance of Joy Child Development Center.

Is There Any Concern We Should Be Aware of?

We can help your child better by being aware of family and home changes. (example: moving, divorce, trouble sleeping, death in the family, parent separation, siblings, etc.) Please let us know.

**CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS****PARENTS' RIGHTS**

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS
(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

LIC 995 (9/08)

Discipline and Guidance Policy

I have read and agree to the discipline policy for Abundance of Joy Child Development Center.

Parent/Guardian Signature: _____ Date: _____

Policy Agreement

I, the parent/Legal Guardian of _____, have received a copy of the policy handbook for Abundance of Joy Child Development Center and I agree to refrain for future reference. I have read the policy, understand them and agree to comply with them while my child is enrolled.

I agree to pay the following tuition amount and understand that these rates may change depending of schedule of rate adjustments during time of enrollment.

Starting Fees _____ I choose to pay: Weekly _____ Monthly _____
Registration Fee paid on _____ Approved Start Date _____

Contract Days: M T W Th F Hours _____

Parent/Guardian Signature: _____
Date: _____

Photography & Videography

I understand that photographs/videos of the children in our programs may appear in newspapers, magazines, brochures, publicity materials and/or educational trainings. Your child's photo will also be posted on our classroom and Facebook sites. I understand that they are to be used without compensation.

Parent/Guardian Signature: _____ Date: _____

**IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BIRTHDATE	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL

☐ OTHER

EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION

DATE LEFT

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)**PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)**

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing:

Allergies: medicine:

Vision:

Insect stings:

Developmental:

Food:

Language/Speech:

Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY)	/ /	/ /			
HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /		
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

- ☐ Risk factors not present; TB skin test not required.
- ☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
- ___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____

Address: _____

Telephone: _____

Date of Physical Exam: _____

Date This Form Completed: _____

Signature _____

☒ Physician ☒ Physician's Assistant ☒ Nurse Practitioner

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME	DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME	DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	MONTHS	BEGAN TALKING AT*	MONTHS	TOILET TRAINING STARTED AT*	MONTHS
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PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

☐ Chicken Pox	DATES	☐ Diabetes	DATES	☐ Poliomyelitis	DATES
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	LUNCH _____
		DINNER _____

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
☐ YES ☐ NO		☐ YES ☐ NO	
WORD USED FOR 'BOWEL MOVEMENT'*	WORD USED FOR URINATION*		

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
☐ YES ☐ NO		☐ YES ☐ NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
☐ YES ☐ NO		☐ YES ☐ NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE
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**CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes**

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

()

WORK PHONE

()

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY

ZIP CODE

AREA CODE/TELEPHONE NUMBER

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

**NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____, give my consent for _____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, _____, and to contact my child's health care
provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

CALIFORNIA SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent record (cumulative folder) as defined in Section 49068 of the Education Code and shall transfer with that record. Local health departments shall have access to this record in schools, child care facilities, and family day care homes.

This record must be completed by school and child care personnel from an immunization record provided by parent or guardian. See reverse side for instructions.

Student Name _____ Sex: M ☐ F ☐ Birthdate _____ Place of Birth _____

Name of Parent or Guardian _____ Race/Ethnicity: ☐ White, not Hispanic ☐ Hispanic ☐ Black ☐ Other: _____ Address _____

Telephone _____ Daytime _____ Nighttime _____ City _____ ZIP _____

VACCINE	DATE EACH DOSE WAS GIVEN					Booster
	1st	2nd	3rd	4th	5th	
POLIO (OPV or IPV)	/ /	/ /	/ /	/ /	/ /	
DTP/DTaP/DT/Td (Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)	/ /	/ /	/ /	/ /	/ /	/ /
MMR (Measles, mumps, and rubella)	/ /	/ /				
HIB (Required only for child care and preschool)	/ /	/ /	/ /	/ /		
HEPATITIS B	/ /	/ /	/ /			
VARICELLA (Chickenpox)	/ /	/ /				
HEPATITIS A (Not required)	/ /	/ /				

TB SKIN TESTS	Type*	Date given	Date read	mm indur	Impression	CHEST X-RAY (Necessary if skin test positive)
☐ PPD-Mantoux		/ /	/ /		☐ Pos	Film date: / / Impression: ☐ normal ☐ abnormal Person is free of communicable tuberculosis: ☐ yes ☐ no
☐ Other		/ /	/ /		☐ Neg	
☐ PPD-Mantoux		/ /	/ /		☐ Pos	
☐ Other		/ /	/ /		☐ Neg	

*If required for school entry, must be Mantoux unless exception granted by local health department.

I. DOCUMENTATION

I certify that I reviewed a record of this child's immunizations and transcribed it accurately:

Date: / /

Staff Signature: _____

Record Presented was:

☐ Yellow California Immunization Record

☐ Out-of-state school record

☐ Other immunization record

Specify: _____

II. STATUS OF REQUIREMENTS

☐ A. All Requirements are met.

Date: / /

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Exemption was granted for:

☐ C. Medical Reasons—Permanent

☐ D. Medical Reasons—Temporary

☐ E. Personal Beliefs

III. 7th GRADE ENTRY

☐ A. All Requirements are met.

Name: _____ Date: _____

☐ B. Currently up-to-date, but more doses are due later. Needs follow-up.

Name: _____ Date: _____

Institution Name: Building Better Communities Foundation

Agreement Number: _____

Facility/Provider Name: _____

Child and Adult Care Food Program (CACFP) Participant Enrollment Form

Dear Parent/Guardian,

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. (In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female

Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No

If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check AM or PM) Arrive: _____ am _____ pm Depart: _____ am _____ pm

School Times: Depart: _____ am _____ pm Return: _____ am _____ pm

If participant is an infant (0-11 months), please complete this box below. Check all applicable choice(s).

This institution/ facility offers _____ formula for infants through CACFP. It is our choice

(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

☐ I will use the formula offered by this facility. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.

☐ I will not use the formula offered by this facility.

If not, which formula will you send for your infant? _____

If the formula you provide is a special formula, a medical statement must be submitted.

☐ I will provide breastmilk for my infant.

☐ My infant is four (4) months old and older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4).

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

Work Telephone Number: _____ Check Work Shift: ☐ 1st ☐ 2nd ☐ 3rd ☐ Other (Specify) _____

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: _____ Date: _____

Date the Participant Withdrew: _____

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.

MEAL BENEFIT FORM FOR CHILDREN

PROGRAM YEAR _____

Name of Child Care Center: _____

Please read the instructions. If you need help completing this form call: (888) 665-4991 _____

Complete, sign, and return form to: Building Better Communities Foundation _____

1. CHILD INFORMATION

(List names of all children enrolled for care)

Check the box if the child is a foster child (the legal responsibility of a welfare agency or court).

Last	First	M.I.	If all children are foster children, go to #4 and sign this form.
			☐
			☐
			☐
			☐

2. BENEFITS

If you are receiving CalFresh, CalWORKs, or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not** complete #3. Go to #4.

CalFresh Case #:
CalWorks Case #:
FDPIR Case #:

3. ALL HOUSEHOLD MEMBERS

Complete this section if you **did not** complete #2. List all household members including children enrolled for care. List all income. Go to #4.

☐ Check here if this household receives no income. Go to #4.

NAMES	GROSS INCOME and how often it was received (e.g. weekly, every 2 weeks, twice a month, monthly, or annually)*			
NAMES OF ALL HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)	EARNINGS FROM WORK BEFORE DEDUCTIONS	CHILD SUPPORT ALIMONY	PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY	EARNINGS FROM ANY OTHER INCOME
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$

*Applicants without income are requested to write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

(PENALTIES FOR MISREPRESENTATION: I Certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

Printed Name:	
Last Four Digits of SSN:	☐ Check here if no SSN
Signature of Adult:	Date:

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) 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 SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or 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 SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove 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. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

If you choose to do so, please mark one or more of the following racial identities:		
☐ American Indian or Alaskan Native	☐ Asian	☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander	☐ White	
Please mark one of the following ethnic identities:		
☐ Hispanic or Latino	☐ Not Hispanic or Latino	

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION 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 www.usda.gov/oc/AD-3027 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

(3) E-mail:

This institution is an equal opportunity provider.

FOR AGENCY USE ONLY	
CATEGORICAL ELIGIBILITY	
CalFresh/CalWORKs/ FDIIR household categorically eligible free ? ☐ Yes ☐ No	
Foster child automatically eligible free ? ☐ Yes ☐ No	
INCOME ELIGIBILITY Annual Conversion: Weekly Times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12	
Total income:	Household size:
Eligibility classification: ☐ Free ☐ Reduced Price ☐ Base	
Determining official (print name):	
Determining Official Signature :	Certification Date:

HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the Meal Benefit Form to: Building Better Communities Foundation If you need help, call: (888) 665-4991

1. CHILD INFORMATION:

- a) Print your child's name. Print your child's name.
- b) Check box to right of name if a foster child.
- c) Include the name of the child care center.

2. BENEFITS: Complete this section and sign the form in #4.

- a) List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
- b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. ALL OTHER HOUSEHOLDS: Complete this section and sign the form in #4.

Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.

- a) Write the amount of income each person received last month before taxes or anything else was taken out and where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported. Each income amount should be entered in the appropriate column on the form. If any amount last month was more or less than usual, write that person's usual monthly income.
- b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
- c) Sign the form and include the last four digits of your SSN in #4. If you do not have a SSN, check the box "Check here if no SSN."

4. LAST FOUR DIGITS OF SSN AND SIGNATURE:

- a) The form must have a signature of an adult household member.
- b) The adult household member who signs the statement must include the last four digits of their SSN. If they do not have a SSN, check the box "Check here if no SSN". The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs or FDPIR case number.

5. RACIAL/ETHNIC IDENTITY: You are not required to answer this question to get meal benefits; but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT		
Earnings from Work: • Wages/salaries/tips • Strike benefits • Unemployment compensation • Worker's compensation • Net income from self-employment Child Support/Alimony • Public assistance payments • Alimony/child support payments	Pensions/Retirement/Social Security • Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security	Other Monthly Income • 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 • Military allowance for off-base housing • Any other income

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE:

American Indian or Alaska Native — A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian — A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American — A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander — A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White — A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY:

Hispanic or Latino — A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino