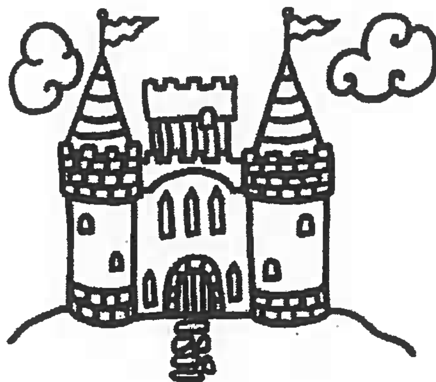


Kid' Kastle
Learning and Activity Center

4710 South Drive
Saint Louis, Mo, 63129
314-892-2004

STUDENT APPLICATION FOR ENROLLMENT

How did you hear about us?

____

____

____

Student name:

____

Student birthday:

____

Student age at time of enrollment:

____

Parent(s) name(s):

____

____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME Kids Kastle	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
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	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

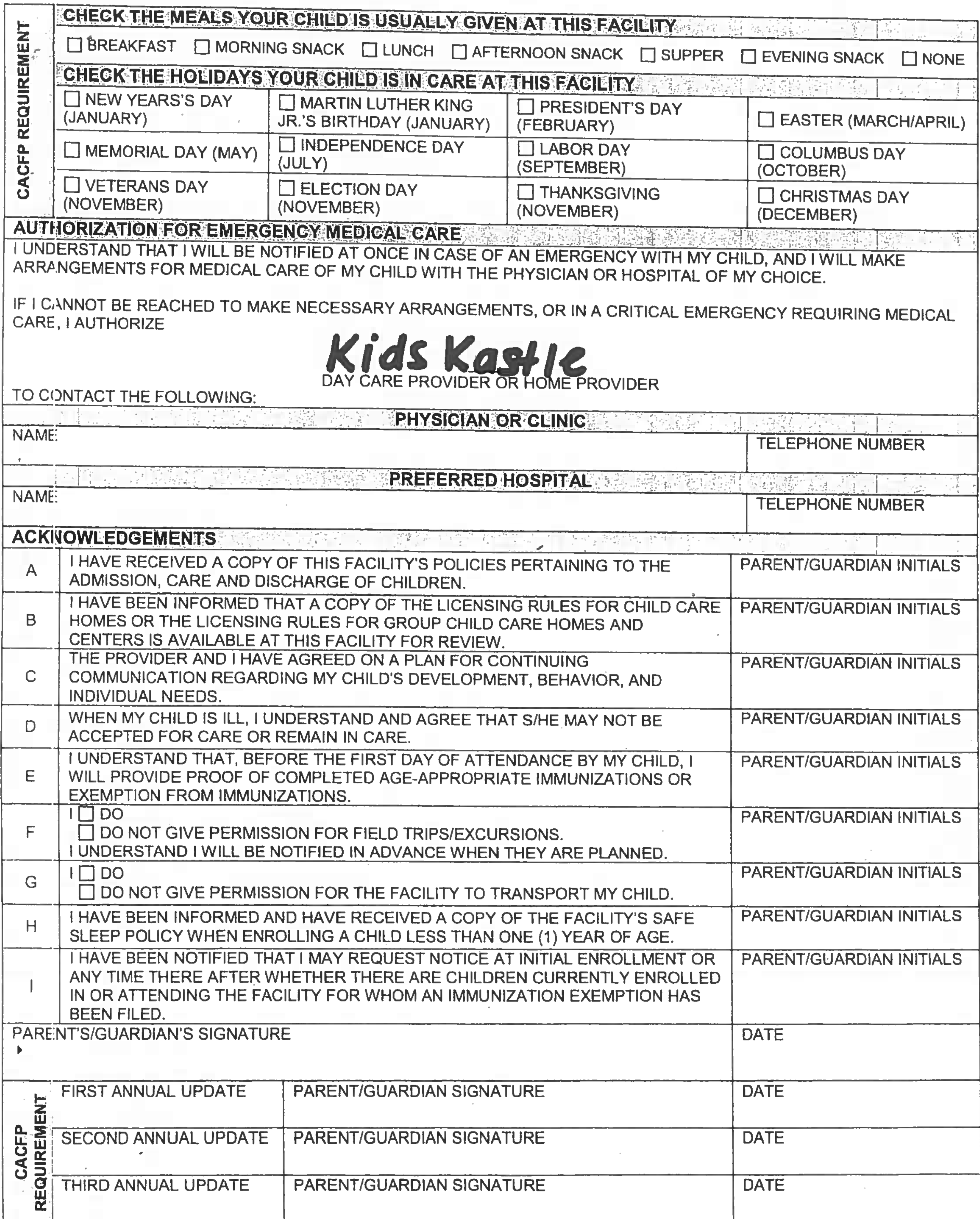
CACFP REQUIREMENT

RELATED CHILD

☐ YES ☐ NO | HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐ FULL TIME OR ☐ PART TIME		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MONDAY	☐	AM PM	AM PM	
TUESDAY	☐	AM PM	AM PM	
WEDNESDAY	☐	AM PM	AM PM	
THURSDAY	☐	AM PM	AM PM	
FRIDAY	☐	AM PM	AM PM	
SATURDAY	☐	AM PM	AM PM	
SUNDAY	☐	AM PM	AM PM	



CACFP REQUIREMENT				
CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY				
☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE				
CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY				
	☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☐ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
	☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☐ COLUMBUS DAY (OCTOBER)
	☐ VETERANS DAY (NOVEMBER)	☐ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ CHRISTMAS DAY (DECEMBER)

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

Kids Kastle
DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC	
NAME:	TELEPHONE NUMBER

PREFERRED HOSPITAL	
NAME:	TELEPHONE NUMBER

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 HOMES AND 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'S/GUARDIAN'S SIGNATURE ▸	DATE

CACFP REQUIREMENT			
	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

STUDENT PROFILE

Name:______________ **Birthday** ___-___-___

Allergies/Food Restrictions:

____

____

Special Needs/Medications:

____

___________________________________.

Who Is Allowed to pick me up:

Name_______________ **Relationship** _______________

Name_______________ **Relationship** _______________

Name_______________ **Relationship** _______________

Name_______________ **Relationship** _______________

ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR CHILD:

____

____

____________________________.

Emergency authorization form

Kids kastle learning and activity center

Child's name: ____________________ **child's date of birth:** ____________________

Mother's name: ____
Employer/school attending: ____
Best daytime contact phone number(s): ____-____-_____ **or** ____-____-_____

Father's name: ____
Employer/school attending: ____
Best daytime contact phone number(s): ____-____-_____ **or** ____-____-_____

Name of friends or relatives other than parents that can be contacted in case of an emergency:

	Name:	relationship:	best number phone #
1.	__________________	__________________	__________________
2.	__________________	__________________	__________________

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I hereby authorize kid's kastle learning and activity center and it's employees to contact:

Doctor/clinic: ________________________ **phone number:** _____-_____-_____
Address: ____

For emergency treatment of my child, my preferred hospital is:

____

(closest hospital is St. Anthony's)

Hospital address:

____

(St. Anthony's is 10010 kennerly road st. Louis, mo, 63128)

Hospital phone number:

____

(st. anthony's phone number is 314-525-1000)

I hereby grant permission for kid's kastle staff to communicate my child's medical condition with medical personnel and to take any steps necessary to obtain emergency medical care for my child. These steps may include, but are not limited to, attempting to contact a parent, guardian, or other emergency contact listed above and/or contacting the child's physician, dentist, hospital, or other medical professional.
If kid's kastle is unable to contact the parent or the child's physician, the facility has permission to call paramedics and/or have the child taken to the emergency room in the company of a staff member. ***all medical expenses are borne by the child's family* kid's kastle is not responsible for any medical expenses or ambulance transportation!!**

Parent signature: ____________________________ __________ **date:** ____________________
(this report is to be kept on file at kid's kastle learning and activity center!

2020- $9 - Please send

Sunscreen Permission Form

I, _______________________ the parent of ______________________, give Kids Kastle Learning Center permission to apply _______________ sunscreen on my child every time the class will be outdoors starting on April 1 and ending on October 31. I understand that sunscreen is a form of medication and by signing this form I consent to the continued use of the sunscreen medication on my child for the dates listed. These dates will remain constant for every year my child is enrolled at Kids Kastle Learning Center. This permission form will automatically be renewed each year unless written notice to discontinue the use of sunscreen is received by Kids Kastle staff from the parent.

X_____________________ I give permission for Kids Kastle to apply the sunscreen to my child ($5.00 due at beginning of season on or before April 1 of the current year)

X_____________________ I do not want sunscreen applied to my child

Bug Spray Permission Form

I, _______________________ the parent of ______________________, give Kids Kastle Learning Center permission to apply _______________ bug spray on my child every time the class will be outdoors starting on April 1 and ending on October 31. I understand that bug spray is a form of medication and by signing this form I consent to the continued use of the bug spray medication on my child for the dates listed. These dates will remain constant for every year my child is enrolled at Kids Kastle Learning Center. This permission form will automatically be renewed each year unless written notice to discontinue the use of bug spray is received by Kids Kastle staff from the parent.

X_____________________ I give permission for Kids Kastle to apply the bug spray to my child ($5.00 due at beginning of season on or before April 1 of the current year)

X_____________________ I do not want bug spray applied to my child

Summer Time FUN!!

Water play permission

Dear parents,

Throughout the summer we have Splash Day THURSDAYS. On splash days, the children will be allowed to participate in various water activities (There is not any pooling of water or swimming). We will need for you to provide swim wear, water shoes, and a towel (Labeled with your child's name) for your child's participation. The swim wear, towel, and water shoes will be stored in your child's cubby during the day, and we ask that you take all of them home to be washed on or before Fridays of the current week. Splash days begin the first Thursday after Memorial Day and end the last Thursday before Labor Day; however, some Thursdays may be excluded due to inclement weather. Children under the age of 2years do not participate in Splash Days, but we ask that you complete this permission form for our files and for your child's future participation when age eligibility permits.

<u>Kid's Kastle is NOT responsible for any injuries caused by water related activities.**</u>**

_____ I understand that Kid's Kastle is NOT responsible for any injuries caused by any water related activities.

I, ____________________, the parent of ____________________, give my child permission to participate in water activities at Kid's Kastle. I have read, understand, and accept the terms and conditions for my child's participation. I also understand my financial responsibility in the event of any injuries and for the subsequent medical attention for my child.

X____________________________
Parent Signature

****if you prefer your child not to participate in our splash day activities please place an "x" in the box to the right** ☐

Tablet Station

In order to clock your child(ren) in and out, each parent/guardian, family member, and friend must obtain their own log in. Please provide the name and current phone number for all persons who may be dropping off or picking up your child(ren).

For faster and more convenient drop offs and pick-ups, you may down the Kinder Smart MO app for smartphones. If you choose this option, please see the office to link your device.

Child Info

Name: ______________________

Siblings:

1. ______________________
2. ______________________
3. ______________________

Parent Info

Mother		**Father**	
Full Name:	______________	Full Name:	______________
Cell:	______________	Cell:	______________
E Mail:	______________	E mail:	______________
4 digit Pin:	______________	4 Digit Pin	______________

Persons Authorized for Drop Off & Pick Up

Full Name	Cell Phone #	4 Digit Pin (Please leave blank)

IMMUNIZATION RECORD REMINDER

Dear parent/Guardian:

Missouri State Law, Section 210.003, RSMo, requires ALL children attending public, private, parochial day care centers, preschools or nursery schools to be adequately immunized, in the process of being immunized, or to have a written exemption on file for the following diseases:

- Diphtheria/tetanus/pertusis (DTap/DT)
- Polio (IPV or OPV)
- Hepatitis B (HB)
- Haemophilus Influenzae type b (Hib B)
- Measles/Mumps/Rubella (MMR)
- Varicella (VZV) or written proof of the disease

Below is the age chart for current vaccinations:

0-2 months.......... 1HB (Hepatitis B)
3-4 months.......... 1(DTap/DT), 1 (Polio), 1 (Hib), and 1 or 2 (HB)
5-6 months.......... 2(DTap/DT), 2 (Polio), 1 or more (Hib), & 2-3 (HB)
7-18 months....... 3(DTap/DT), 2 (Polio), 1 or more (Hib), & 2-3 (HB)
19 month-Kinder .....4(DTap/DT), 3 (Polio), 1 or more (Hib), 3 (HB)
**After 12 months of age 1(MMR), 3(HB), & 1 Varicella (chicken pox) vaccination required **

Proof of these immunizations is required by law. Failure to provide the immunization record will result in the inability for Kid's Kastle enrollment and/or the immediate discharge of currently enrolled students. These documents can be faxed, mailed, or hand delivered to the facility.

Phone number: (314) 892-2004
Address: 4710 South Drive Saint Louis, MO 63129
Fax Number: (314) 892-2004 (same as phone number. Please call in advance and we will be glad to connect the fax machine!

Evidence of Blood Lead Testing

Child's name: ____

Child's Date of Birth: ________________

Receipt of Test

Received a Venous / Capillary blood lead test on ____________________**(date).**
(Circle one.)

Test was administered by: ____
(Signature of Medical Provider)

Medical Provider Address (City, State, Zip Code)

____

____

____

Refusal of Test

I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the age of six years. I do object to my child being blood tested in order to determine if he/she is lead poisoned.

Reason for Refusal ____

Signed ____ **Date:** __________
(Parent/Guardian)

Relation to Child: ____

Parent/Guardian Address (City, State, Zip Code)

____

____

____

Provide patient with two copies: One for record
One for child-care provider

One copy should be retained in patient's chart.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

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.)

____

____

____

____

____

____

____

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____

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

Kid's Kastle has a website address, www.kidskastlelearningandactivitycenter.com, where we provide pictures and literature for current and potential customers. Furthermore, throughout the year, we take pictures of the children participating in various activities. Below is a permission form to include or exclude your child's picture from our website. No child's names will be written on the website.

I, ________________, the parent of _____________ give permission for Kid's Kastle to include my child's picture on the above named website.

X___________________________

Parent/Guardian Signature

☐ **Place an X in the box if you do NOT want your child's picture included on our website.**

September 18, 2013

Dear Parents,

IMMEDIATE attention is required to assure the safety of all of our students and staff. Medication storage and distribution is a very serious safety concern and with the help of all the parents and continued staff training I am sure we can ensure correct medication procedures per policy! As many of you already know, a medication permission form must be on file for every medication that is to be distributed to your child while under supervision of Kid's Kastle staff. However, while reviewing files, many incomplete and/or inaccurate forms were brought to my attention. Attached to this letter please find a fully completed and accurate medication permission form!

POLICY REMINDERS:

___*Medication forms must have child's full legal name, complete name of medication, and dosage prescribed to child clearly labeled.

___*The dates the medication is to be distributed must be specific dates (mm/dd/yy) to (mm/dd/yy) format **IMPORTANT** as needed/no expiration is NOT acceptable.

___*For all over the counter (OTC) medications (ex: Tylenol, Benadryl, Ibuprofen, Teething tabs, Gas drops), a medication form is only valid for one week (starting on Mondays and expiring on Fridays of the same week). If for any reason your child requires OTC medications for longer than one week, a new medication form must be filled out each week on the child's first day of attendance.

___*ALL MEDS WILL BE SENT HOME ON OR BEFORE FRIDAYS! Any medication left on Fridays will be thrown out at close of business at parent's expense.

___*In addition to specific dates, the medication form must have specific times for the medication to be administered (once a day, twice a day, every_ hrs, or as needed are NOT acceptable). Must clearly read the specific times of day (ex: 8:00am, 12:00pm, and 4:00pm)

___*If your child has any condition that requires a medication on an "irregular" or "as needed basis" such as Asthma or Allergies which require an inhaler or Epi Pen, a written action plan from the primary doctor is required detailing the signs and symptoms of when/how/where to administer the medication and the follow up care procedure in the event an attack would occur.

___**KIDS KASTLE STAFF CANNOT ADMINISTER THE FIRST DOSE OF ANY NEW MEDICATIONS (This includes Over the Counter medications in sealed containers)!!**Medication cannot be expired.

___*NO MEDICATIONS left in student's bag or cubby at any time for any reason, that is a very serious state law violation. Meds must be labeled with child first and last name on a zip loc bag and placed in correct closet for storage.

___**ALL STAFF HAVE BEEN TRAINED TO NOT ACCEPT MEDICATIONS WITH OUT A COMPLETE AND ACCURATE MEDICATION FORM ON FILE (please allow yourself sufficient time at drop off to complete the appropriate forms if needed). Any medication without a medication form on file will be discarded at parent's expense!

I understand the MEDICATION STORAGE/DISTRIBUTION POLICY ______________________________

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2019 through June 30, 2020

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.

Family Size	Yearly Income	Family Size	Yearly Income
1	$23,107	5	$55,815
2	$31,284	6	$63,992
3	$39,461	7	$72,169
4	$47,638	8	$80,346
		For each additional Family Member, add	+$8,177

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-3027) found online at:
http://www.ascr.usda.gov/complaint filing cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Child and Adult Care Food Program
INCOME ELIGIBILITY GUIDELINES
July 1, 2019 – June 30, 2020

Free Meals – 130% | **Reduced-Price Meals – 185%**

Household Size	Yearly	Monthly	Twice a Month	Every 2 Weeks	Weekly	Household Size	Yearly	Monthly	Twice a Month	Every 2 Weeks	Weekly
1	16,237	1,354	677	625	313	1	23,107	1,926	963	889	445
2	21,983	1,832	916	846	423	2	31,284	2,607	1,304	1,204	602
3	27,729	2,311	1,156	1,067	534	3	39,461	3,289	1,645	1,518	759
4	33,475	2,790	1,395	1,288	644	4	47,638	3,970	1,985	1,833	917
5	39,221	3,269	1,635	1,509	755	5	55,815	4,652	2,326	2,147	1,074
6	44,967	3,748	1,874	1,730	865	6	63,992	5,333	2,667	2,462	1,231
7	50,713	4,227	2,114	1,951	976	7	72,169	6,015	3,008	2,776	1,388
8	56,459	4,705	2,353	2,172	1,086	8	80,346	6,696	3,348	3,091	1,546
For each additional family member, add:	+5,746	+479	+240	+221	+111	For each additional family member, add:	+8,177	+682	+341	+315	+158

Note: Only provide the income guidelines for reduced price meals to the parents. The Parent Letter provides the income guidelines.

Using the Income Eligibility Guidelines

The income eligibility guidelines are used to categorize the household income reported on the IEF into either the free, reduced-price or paid meal category.

For example:

- If the monthly income for a family of two is $1,832 or less, the center would claim the child at the free rate.
- If the household income for a family of two is between $1,832 and $2,607 per month, the center would claim the child at the reduced-price meal rate.
- If the household income for a family of two is $2,608 or more per month, the center would claim the child at the paid meal rate.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

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.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

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 ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

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 children'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 member 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 ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐ SNAP (Food Stamp) ☐ TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE ▶ | DATE

MO 580-1314 (2-11) CACFP-205