Guardian Enrollment Checklist

We are so happy you are interested in becoming a part of Clever Bee Academy. To get started, please complete all applicable items below and returned to the Center Director.

Section 1: PFCC APPLICATION

- ☐ **Submit PFCC Application or Provider Change Form to Center Director**
  (If just changing child care provider only Provider Change Form is required and can be filled out and submitted via fax at our center. No additional documents in this section is needed.
- ☐ **Proof of Income:** Verification of all money coming into your household (such as one-month of recent paystubs, tax records, award letters, child support)
- ☐ **Proof of citizenship or qualified alien status of each child in need of care** (such as birth certificate, SSI card)
- ☐ **Proof of any child support paid *(if applicable)***
- ☐ **Proof of all qualifying activity for all caretakers in the household:** Verification of a qualifying activity includes but not limited to an official school schedule, work scheduled, self-sufficiency contract, etc.
- ☐ **1401-Form has been fill out completely and signed with PFCC Application** (Columbus families only)

Section 2: Clever Bee Academy Enrollment Application

- ☐ **Clever Bee Academy Enrollment Application** includes but not limited to:

- ☐ **JFS 01234 Form (2016)** – If any area is marked “Yes” on page 2, you must create a JFS 01236 "Medical/Physical Care Plan" or a JFS 01217 Request for Administration of Medication.
  JFS 01236 “Medical/Physical Care Plan” or JFS 01217 Request for Administration of Medication Needed:

- ☐ **JFS 01305 Form** – Medical Statement completed by doctor (You have 15 days from start date to complete)

- ☐ **Shot Records** needed to start for all children not in grade school *(No required for children in K-12)*

- ☐ **Photo/Video Release Form**

- ☐ **Pick-Up Form**

Section 3: Child and Adult Care Food Program

- ☐ **CACFP Income Eligibility Form**

- ☐ **CACFP Income Enrollment Form**

- ☐ **CACFP Infant Meals – Parent Preference Letter**

Family Information

Required by Ohio Administrative Code

The facility is licensed to operate legally by the Ohio Department of Job and Family Services.

This license is posted in a conspicuous place for review, in most cases the academy's office.

A toll-free telephone number is listed on the facility's license and may be used to report a suspected violation of the licensing law or administrative rules.

The licensing law and rules governing child care are available for review at the facility upon request.

The administrator and each employee of the facility are required, under Section 2151.421 of the Ohio Revised Code, ORC to report their suspicions of child abuse or child neglect to the local public children services agency.

Any parent, custodian or guardian of a child enrolled in the facility shall be permitted unlimited access to the facility during all hours of operation for the purpose of contacting their children, evaluating the care provided by the facility or evaluation of the premises. Upon entering the premises, the parent or guardian shall notify the administrator of his/her presence.

The administrator's hours of availability and child/staff ratios are posted in a noticeable place in the academy for review.

The licensing record, including licensing inspection reports, complaint investigation reports, and evaluation forms from the building and fire departments, is available for review upon written request from the Ohio department of job and family services.

It is unlawful for the facility to discriminate in the enrollment of children upon the basis of race, color, religion, sex or national origin or disability in violation of the Americans with Disabilities Act of 1990, 104 Stat. 32, 42 U.S.C. 12101 et seq.

For more information about child care licensing requirements as well as how to apply for child care assistance, Medicaid health screenings and early intervention services for your child, please visit http://jfs.ohio.gov/cdc/families.stm

Clever Bee Academy reserves the right to dis-enroll a child(ren) at any time for any reason.

_____ _____

Parent's/Guardian's Signature Date

Handbook Acknowledgment

I have received, read and fully understand the information in Clever Bee Academy's Family Handbook and applicable handouts provided. An academy staff member has interviewed me and thoroughly explained the admission policies, fees, academy policies and state policies. I understand all of the applicable policies and agree to abide by them.

Parent/Guardian/Caregiver (Print): _____

Signature: _____

Date: _____

Academy Director/Academy Management Team Member (Print):

_____

Signature: _____

Date: _____

Academy management team: place this signed page in the child's file.

Clever Bee Academy (Corporate Office)

1111 Superior Ave E, Suite 404
Cleveland, OH 44114
216-454-2625
info@cleverbeeacademy.com
www.cleverbeeacademy.com

Child Information for Ohio Academies

(each child in the academy must have a completed form)

Child's Name:		Birthdate:	First Day at Academy:
Home Address:		City:	
State:	Zip:	Home Telephone Number:	

CHILD PICK UP INFORMATION

By initialing this section I give permission for the people listed below to pick up my child(ren). I have informed all parties who will be picking up my child(ren) that they must have proper picture ID and they must be at least 18-years-old. _____ Parent's/Guardian's Initials

Name of Person Permitted to Pick-up Child(ren):	Phone Number:	Relationship
Name of Person Permitted to Pick-up Child(ren):	Phone Number:	Relationship
Name of Person Permitted to Pick-up Child(ren):	Phone Number:	Relationship
Name of Person Permitted to Pick-up Child(ren):	Phone Number:	Relationship
Name of Person Permitted to Pick-up Child(ren):	Phone Number:	Relationship

Dear Parent/Caregiver:

Welcome to Clever Bee Academy! Your child's first five (5) years of life set the stage for learning and school readiness and we want to partner with you to help provide the best start for your child. With your written consent, as part of this partnership our teachers will complete the Ages & Stages Questionnaires, Third Edition (ASQ-3) and the Ages & Stages Questionnaire, Social Emotional (ASQ-SE) along with your input to help you keep track of your child's development. These very brief screening tools ask questions about your child's communication, gross motor, fine motor, problem solving, and personal-social skill development. Your consent and participation in this process is very important to assist in monitoring your child's school readiness skills.

Please read below and indicate whether or not you will give consent for your child to participate in our screening program.

- I have read and understand the above information. I give consent to have my child participate in the screening program.

- I have read and understand the above information. I do not give my consent to have my child participate in the screening program.

Parent/guardian Signature

Date

Child's name

Child's date of birth

If your child was born three (3) or more weeks prematurely, please give the number of weeks premature_____

Getting to Know You

Enrollment Date: _____

Clever Bee Academy offers a *Getting to Know You* to all new families within 45 days of enrollment. The meeting covers 1) Clever Bee Academy introduction and history; 2) academy staff introduction and child room assignments; 3) Brightside Academy's Home Connections Program; 4) Review of the Family Handbook and state regulations; and 5) Keystone STARs requirements (Pennsylvania only)

To request a meeting, return the attached meeting request form to your academy director. If you decline the meeting you will be required to completed the child information section below return it to your academy director within 45 days of enrollment. Contact your academy director or 1-877-868-CARE with questions.

By signing I acknowledge I have read, understand and agree to follow the Getting to Know You program.

Parent's/Guardian's Signature:_____ Academy Director's Signature:_____

MEETING REQUEST: Parents can request a meeting the academy director within 45 days from your child's enrollment date

Child's Name:	Birthdate:
Parent's Name:	

□ I would like to request a Getting to Know You meeting with my child's academy director at the academy location. I understand that this meeting will take place 45 days from the date of my child's enrollment date.

Choice #1: Date_____ Time_____

Choice #2: Date_____ Time_____

□ I decline the option of having a Getting to Know You meeting with the academy director at my child's academy location. I will completed the below sections and return this form to the academy director within 45 days of my child's enrollment date.

PARENT/GUARDIAN INFORMATION This section provides Clever Bee Academy with vital information on your expectations, desires and information you feel we need to know about your child.

Name:	Home Number:
Mobile Number:	Work Number:
Email Address	

Tell us the best way to contact you: □ Home Number □ Mobile Number □ Work Number □ Email

1. What are your expectations of Brightside Academy's program?

2. Is there a particular aspect of Brightside Academy's education program especially important to your family?

3. Is there information about your family's culture, ethnicity, language or religion that is important for us to know (celebrations, dietary restrictions)?

4. Would you and/or your family like to be a resource for any cultural awareness activities? □ Yes □ No

5. Are you interested in volunteer opportunities in our classrooms? □ Yes □ No

Provide additional information you feel is important for Clever Bee Academy to know to provide the best possible care for your child.

CHILD INFORMATION The section provides Clever Bee Academy with information on your child's likes, dislikes and special needs. Complete this section to the best of your knowledge.

1. Describe your child's likes and dislikes.

2. List the activities your child enjoys (reading, tummy time, music, playing outdoors, etc.)

3. List your child's favorite toys.

4. Does your child respond to a nickname? □ Yes □ No If yes, what is it? _____

5. Does your child have allergies? □ No □ Yes
If yes please list: □ Food _____ □ Environmental _____ □ Medicine _____
How is the allergy treated?_____

6. What is your child's schedule? Bed time _____ Waking time _____
Nap time _____ Meal times _____

7. Is your child toilet trained? □ Yes □ No Are there any tips you would like to give us to aid in this training? _____

Provide additional information you feel is important for Clever Bee Academy to know to provide the best possible care for your child.

CHILD WITH SPECIAL NEEDS INFORMATION The section provides Clever Bee Academy with information on your child's likes, dislikes and special needs. Complete this section to the best of your knowledge.

1. Does your child have special needs (medical, developmental, social, mental health, etc.)? □ Yes □ No *If yes, please complete this section.*

2. List your child's special needs.

3. Does your child have an Individual Education Plan (IEP) or an Individual Family Service (IEFS)? □ Yes □ No If yes, provide us with a copy of the plan so we can provide the best possible learning experience for your child.

4. List all programs and/or individuals who work with your child in regard to the above needs.

Will you sign a release of information with the program/individual so we may communicate with them about how to provide enhanced support for your child? □ Yes □ No

Provide additional information you feel is important for Clever Bee Academy to know to provide the best possible care for your child.

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation**.**

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**OR** **Do not sign both**	***Do Not Give Permission* to Transport**	
Program or Home Name				Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.				**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date			Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below)*:

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below)*

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent** Date

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

Child's Name	Date of Birth *(if needed to determine the correct dosage)*	Weight *(if needed to determine the correct dosage)*

Box 1 The following section must always be completed by the parent/guardian.

Name of medication	Dosage	
	☐ See attached	
To be administered at the following times	For the following period of time	Medication expiration date

I understand:

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *That my child must receive at least one dose of medication at home prior to the program administering the medication (unless the medication is used for emergencies).*

Signature of Parent/Guardian	Date

Box 2 The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant when any of the following apply:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period;
5. The intended use differs from the manufacturer's instructions or use

Instructions

☐ See Attached

Possible side effects to watch for are

☐ See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant	Date of Signature

Phone Number

This form shall be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication

Date	Time	Dosage	Signature of designated person administering medication

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods.
- Administering procedures which require staff to be trained on those procedures
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication is documented on this form, then a JFS 01217 is not required.

Child's Name	Date of Birth

Special Health Condition

Does the condition require medication?

☐ Yes

☐ No

☐ **Check here if questions 1 through 7 are included on a separate sheet with physician's instructions.**

1. What are the symptoms to watch for?

2. When should the medication or medical food be administered?

3. What are the instructions for administration?

4. What triggers the need for medication or medical foods?

5. What are the expected results of the medication or medical foods?

6. What are the actions to be taken if symptoms do not subside?

7. What are the activities, foods, environmental conditions to avoid? ☐ Not applicable

Training instructions *(include all steps to administer the medication or perform the medical procedure)*

☐ Included on attached physician's instructions

If expected result of medication or medical food does not occur:

☐ Check here if Emergency Medical Services (9-1-1) is to be contacted

NOTE: If Emergency Medical Services (9-1-1) is to be contacted, the parent/guardian is also to be contacted immediately.

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have been trained in performing the procedure for this child.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.

Administrator/Provider Signature	Date of Signature

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication

Date	Time	Dosage	Signature of designated person administering medication

Photo/Video Release Form

Clever Bee Academy frequently posts pictures and videos on it's website and social media platforms. Our goal is to share feedback with parents, potential parents, friends and the community regarding the quality care and education the children are receiving. Your child may potentially be in one of the postings and we'd love to get your permission to share it! Please carefully read and sign the agreement below so that your child will have the chance to be seen in a fun educational environment.

I,_____, am the parent or legal guardian of_____
("my child"), a participant in a Clever Bee Academy program for children ages 6 weeks to 12 years old
I hereby consent to the publication and use of my child's name and/or my child's likeness ("Likeness") and my likeness for the purpose of promotion, publicity, advertising, or other manner or media by Clever Bee Academy or any other representative authorized to act on behalf of the afore-mentioned entity. The photographic pictures and/or videos may be altered in character or form on reproductions in color and/or black and white through any media used by Clever Bee Academy for any Clever Bee Academy purpose including, without limitation, photographs, sound and/or video recordings, films, broadcasts, brochures, publications, reports, use on any websites and/or social media, promotional materials or any other audio-visual, electronic, printed, tangible work in any media or format, now known or hereafter to become known, and/or reproductions of any of these.

On behalf of myself and my child, I agree that the actual material involved is and shall continue to be the property of Clever Bee Academy and that neither I, nor my child, shall have any right of review or approval regarding the use of my child's name and/or Likeness, or my likeness in such material.

I hereby release and hold harmless, Clever Bee Academy. along with their respective employees, agents, affiliates, sponsors, or other representatives from any and all claims, demands, or causes of action arising out of the use of my child's name and/or Likeness or my likeness, in accordance with the terms of this release. I understand and agree that neither I, nor my child, will be compensated in any way for the use of my child's name and/or Likeness by Clever Bee Academy.

I am over 18 years of age and competent to contract in my own name. I have the authority to execute this document on behalf of my minor child

Child's name (printed):_____ Age:_____

Parent/Guardian name (printed): _____

Parent/Guardian signature: _____ Date:_____

Address: _____

Phone:_____ Email: _____

CACFP
ENROLLMENT FORM

Requirements:

a. CACFP child care centers and Head Start centers must have a completed CACFP Enrollment Form on file for each enrolled child. Siblings must have a separate form as attendance may be different.

b. The CACFP Enrollment Form is valid for 12 months following the month of parent/guardian dated the form. For example: Parent dated the form on 7/13/2015; form would expire on 7/31/2016). CACFP Enrollment forms must be completed annually by parent/guardian.

c. The following CACFP program types DO NOT need CACFP Enrollment forms:
   - Outside-School Hours Centers
   - Youth Development Programs
   - After School At Risk Programs
   - Emergency Shelters

Enrollment Form Reminders

- List one child per form
- All parts of form to be completed by parent/guardian including normal days, hours and meals
- If parent/guardian work schedule varies frequently thus the child's attendance pattern will also change frequently then parent should check the box at the bottom of the chart. Parent/guardian is not required to complete another form but may elect do so.
- For ease of collection, it is highly recommended that agencies/centers distribute enrollment forms to parents/guardians at the same time as the Income Eligibility Application so that it is more likely that the forms would expire on the same date.
- If sponsor decides to develop own CACFP enrollment form, form contain all required information and be approved by State Agency prior to use.

ATTACHMENTS

- State Agency Prototype CACFP Enrollment Form
- Example of completed CACFP Enrollment form

Ohio Department of Education - Office for Child Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME (please print)	**AGE**	**BIRTHDATE** / / month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		**List Hours Child Normally in Care**				**Check (✓) Meals Child Normally Receives while in Care**					
		Arrive	**Depart**	**Arrive**	**Depart**	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Supper**	**Evening Snack**
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ **Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule**

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**

MAILING ADDRESS:
STREET /APT. **CITY** **ZIP CODE**

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:
(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; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider. (rev. 12/3/2015)

Ohio Department of Education - Office for Child Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME *Sunshine Child Care*

CHILD'S NAME (please print)	**AGE**	**BIRTHDATE**
ANNIE JONES	**5**	**9** / **4** / **2009** (month / day / year)

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday	✓	7:00 am	8:15 am	4:15 pm	6:00 pm	✓			✓		
Tuesday	✓	7:00 am			6:00 pm	✓		✓	✓		
Wednesday	✓	7:00 am	8:15 am	4:15 pm	6:00 pm	✓			✓		
Thursday	✓	7:00 am			6:00 pm	✓		✓	✓		
Friday	✓	7:00 am	8:15 am	4:15 pm	6:00 pm	✓			✓		
Saturday											
Sunday											

EXAMPLE

☐ **Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule**

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**
Mary Jones	*7/13/2015*	*(614) 222-3344*

MAILING ADDRESS:
STREET /APT. *123 Park St.* **CITY** *Columbus* **ZIP CODE** *43215*

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:

(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; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

(rev. 12/3/2015)

CLEVER BEE ACADEMY
EARLY EDUCATION & CHILD CARE

Infant Feeding Schedule and Information Sheet

General Information

Parent's/Guardian's First and Last Name: _____

Child's First and Last Name: _____ Child's Birthdate: _____

Formula

Formula Type: _____

Number of ounces per feeding: _____ oz. How often: _____

Additional Information: _____

_____

_____

Juice Bottle Schedule

Juice Type: _____

Number of ounces per feeding: _____ oz. How often: _____

Note: Juice is NOT provided by Clever Bee Academy. If you would like your child to have juice, you can bring it and store it in the academy's refrigerator.

Food Program

The following foods are provided by Clever Bee Academy in participation with the CACFP Food Program. Please check the box next to the foods/formula your child is allowed to have:

Formula: ☐Enfamil with Iron ☐ Prosobee

Cereal: ☐ Rice ☐ Oatmeal ☐ Mixed

Fruits: ☐ Applesauce ☐ Peaches ☐ Pears ☐ Bananas

Vegetables: ☐ Carrots ☐ Squash ☐ Green Beans ☐ Peas ☐ Sweet Potatoes

What does your child eat for breakfast? _____ Time: _____

What does your child eat for lunch? _____ Time: _____

What does your child eat for dinner? _____ Time: _____

Parent's/Guardian's Signature: _____ Date: _____

Academy Director's Signature: _____ Date: _____

MAINTAINING RECORDS:

Food program records (including income eligibility applications) must be kept on file for at least three years plus the current fiscal year, or longer if there is an unresolved evaluation/audit. The state agency has developed a master list form that center-based programs (excluding Head Start, Early Head Start, After School At- Risk Programs and Homeless/Domestic Violence/Emergency Shelters) should use to record which category each child is claimed and to simplify the monthly claim for reimbursement. A copy is available for download on the ODE website, education.ohio.gov.

INCOME ELIGIBILITY GUIDELINES:

Free and reduced-price income eligibility guidelines are updated each year by the Federal government on July 1. The guidelines effective July 1, 2023 through June 30, 2024 are noted on page 8. You must use this two-part chart and not the reduced-price guidelines on the household letter when categorizing and approving the income eligibility application. Do not distribute this chart to parents/families.

The income eligibility guidelines (on page 8) list the household size, the income for different pay periods/schedules (annual, monthly, twice per month, every two weeks and weekly), and show the upper income levels for the free and reduced-price categories. After reviewing an income application/form and determining the number of people in the household and the total household income, compare the household income to the correct pay period/schedule.

- To determine whether a child qualifies for **free** meals, the total household income must be equal to or less than the free income guidelines.
- To determine the **reduced-price** category, the household income must be equal to or less than the reduced-price income guideline, but greater than the free guidelines.
- An income application falls into the **paid** category when the household income is above the reduced-price household income.

REMINDERS FOR INCOME DETERMINATION

If the household has only one income source, or if all sources are received in the same frequency (annually, monthly, twice per month, every two weeks or weekly), compare the income or sum of the incomes to the income eligibility guidelines for that household size and pay frequency to determine eligibility and category.

Example: Jim Taylor $ 1,527 / every two weeks
Mary Taylor $ 843 / every two weeks
$ 2,370 / every two weeks

On the income eligibility guidelines chart, compare the household size to the income listed in the “every two weeks” column to determine category.

If the household reports income sources at more than one frequency (annually, monthly, twice per month, every two weeks or weekly), all the incomes must be converted to annual (yearly) totals by using the following annual income conversion: weekly income X 52, bi-weekly (every other week) income X 26, bi-monthly (twice per month income X 24 and monthly income X 12. Do not round income amounts resulting from each conversion. After converting each income to annual income, add the incomes together. Then compare the number of household members to the total annual income on the income eligibility guidelines chart to make the eligibility determination/categorization.

Example:	Bob Smith	$ 800 / every two weeks	(800 x 26 = $20,800)
	Jane Smith	$ 228 / weekly	(200 x 52 = $11,336)
		$ 153 / twice per month	(150 x 24 = $ 3,672)
		$ 100 / monthly	(100 x 12 = $ 1,200)
		Total household income totals	$ 37,008 annually

USDA INCOME ELIGIBILITY GUIDELINES
Fiscal Year 2024
Effective July 1, 2023 through June 30, 2024

Households with total incomes less than or equal to the values below are eligible for free or reduced-price meals.

	FREE					REDUCED-PRICED				
HOUSEHOLD SIZE	ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY	ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	$18,954	1,580	790	729	365	$26,973	2,248	1,124	1,038	519
2	$25,636	2,137	1,069	986	493	$36,482	3,041	1,521	1,404	702
3	$32,318	2,694	1,347	1,243	622	$45,991	3,833	1,917	1,769	885
4	$39,000	3,250	1,625	1,500	750	$55,500	4,625	2,313	2,135	1,068
5	$45,682	3,807	1,904	1,757	879	$65,009	5,418	2,709	2,501	1,251
6	$52,364	4,364	2,182	2,014	1,007	$74,518	6,210	3,105	2,867	1,434
7	$59,046	4,921	2,461	2,271	1,136	$84,027	7,003	3,502	3,232	1,616
8	$65,728	5,478	2,739	2,528	1,264	$93,536	7,795	3,898	3,598	1,799
Each Additional Member Add	$6,682	557	279	257	129	$9,509	793	397	366	183

ANNUAL INCOME CONVERSION:

Weekly Income multiply by 52
Every Two Weeks Income (bi-weekly) multiply by 26
Twice Per Month Income (semi-monthly) multiply by 24
Monthly Income multiply by 12

This chart is to be used by institutions, schools, centers and sponsoring organizations to approve and categorize complete income eligibility applications for free and reduced-price meals.

This chart is not to be distributed to families/participants.

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2023-2024

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an a*dult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation)
1.			☐
2.			☐
3.			☐
4.			☐

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.

Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)

CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	☐	$ amount / how often	$ amount / how often	$ amount / how often	$ amount / how often
1.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
6.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* _____ SIGNATURE OF ADULT HOUSEHOLD MEMBER	* _____ DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number ☐☐☐☐ (Check if applicable) ☐ I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American
☐	Native Hawaiian or Other Pacific Islander	☐	White	☐	Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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. **State Distribution: July 2023**

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion :
Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

☐ **FREE,** based on ☐ Food Assistance/OWF Case No.
☐ Household size and income
☐ Foster Child

☐ **REDUCED-PRICE**, based on Household size and income

Total Household Size: _____

Total Household Income: $_____

Per: ☐ week ☐ every two weeks ☐ twice per month ☐ month ☐ year

☐ **PAID,** based on ☐ Income too high
☐ Incomplete
☐ Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date (From the first of month of date signed)	Expiration Date (Valid until last day of month in which form was signed one year earlier)

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

HOUSEHOLD LETTER - Dear Parent or Guardian

Please help us comply with the requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. **The completion of the income eligibility application is optional.** Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits**.** An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced-price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (*denotes required info)

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Attach documentation to show foster child status.

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.

PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.

a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

b) Check the box for any person listed as a household member (including children) that has no income.

c) For each household member, list each type of income received during the last month and list how often the money was received.

1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and 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.
2. List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

a) * All applications must have the signature of an adult household member.

b) * The adult signing the application must also date the form.

c) * Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

NON-DISCRIMINATION 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 (including gender identity and sexual orientation), 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: How to File a Complaint, 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; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

REDUCED-PRICE INCOME ELIGIBILITY GUIDELINES
Effective from July 1, 2023 through June 30, 2024. Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.

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

General Acknowledgement of Forms

☐ I hereby acknowledge and agree that I had read all of the forms and documents provided to me in connection with evaluation and treatment provided by FM Speech Therapy DBA TheraPeds and/or their affiliates/employees.

☐I hereby acknowledge and agree that I have viewed, read, and understand the HIPAA Policy and have been informed of my rights as a patient's parent/guardian.

☐I hereby acknowledge and agree that I have viewed, read, and understand the payment policy.

☐ I understand the meaning and intent of the provided forms and agree to all content included.

☐ I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by FM Speech Therapy LLC DBA TheraPeds.

Consent Form

☐ I authorize FM Speech Therapy LLC DBA TheraPeds to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by TheraPeds in writing. I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and FM Speech Therapy LLC staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered. In addition, TheraPeds may terminate services by notifying me in writing.

☐ I authorize FM Speech Therapy LLC DBA TheraPeds and its affiliates to the release of information to and from Brightside Academy and all members of my child's medical or educational team. I consent for FM Speech Therapy LLC DBA TheraPeds, via all means of communication, to release and receive information that may include but is not limited to speech/language and hearing records, medical reports, academic information and program planning.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Participant or Legal Representative Relationship to Client

_____ Date: _____
Name of Participant or Legal Representative

Child Intake Form / History

Parent(s) / Guardians: _____
Address: _____
City, State, Zip: _____
Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Email #1:_____

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom: _____

Is the child currently taking any medication? ☐ Yes ☐ No
Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Does the child have any known allergies? ☐ Yes ☐ No
Describe: _____

Child's Health:
1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)
2. The child was _____ lbs ____oz and _____ inches at birth
3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section
4. Please describe any complications or concerns during labor or delivery:
_____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐PT _____
☐OT _____
☐SLP _____

Which Medicaid managed care plan is your child on?
Please provide a copy of your insurance.