Guardian Enrollment Checklist

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

Section 1: TITLE XX APPLICATION

- ☐ **Submit Title XX 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 Title XX Application** (Columbus families only)

Section 2: Brightside Academy Enrollment Application

- ☐ **Brightside 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**

Brightside Academy Ohio - Enrollment Application

GENERAL INFORMATION (This section to be completed by academy)	
Academy # Enrolled by: Brightside Emp. Position:	Desired Start Date: Today's Date:

PARENT'S INFORMATION	
Name:	Social Security Number:
Street Address:	
City/State/Zip:	

Home Phone:	Cell Phone:	Work Phone:
Email Address:		□ Yes □ No May we contact you via email?

CHILD INFORMATION	CHILD INFORMATION
Name:	Name:
D.O.B.:	D.O.B.:
Drop-off Time: Pick-up Time:	Drop-off Time: Pick-up Time:
Days (please circle) M T W Th F	Days (please circle) M T W Th F
CHILD INFORMATION	**CHILD INFORMATION**
Name:	Name:
D.O.B.:	D.O.B.:
Drop-off Time: Pick-up Time: Days (please circle) M T W Th F	Drop-off Time: Pick-up Time: Days (please circle) M T W Th F

PROGRAM/EMPLOYER INFORMATION	
□ School □ Training □ Job Search □ Working	□ Brightside Academy Employee
Name of School, Training Program or Employer:	Employer Phone: ( ) Fax: ( )
Start Date: End Date:	Brightside Academy Employee Title:

TUITION AND FEE POLICY

Fees and Co-payments: Private fees and co-payments are due each Monday of the week care is provided. Full weekly payment is due regardless of the number of days attended. Payment is not required for holidays and in-service days. There are no vacation days or weeks permitted.

Non-payment Policy: If paying private, care will be terminated if the client has not paid for two weeks. Pay is based on enrollment not attendance. Subsidy client will be reported to their subsidy office for non-payment of weekly co-payments.

Returned Check Fee: Checks returned for insufficient funds, closed accounts or stopped payments will result in a $35.00 returned check charge. All future payments (including the $35.00 charge) will then be required to be made by cash, money order, credit card or certified check.

Late Fee: There is a $1.00 per minute late fee assessed after the designated closing time per child.

TAP System: Families must enter their child in/out of the Time, Attendance, & Payment System (TAP) each day upon arrival and departure and accompany them to their classroom. Families must review and approve all pending authorizations daily.

_____ PARENT'S/GUARDIANS INITIALS

FUNDING INFORMATION	
Funding Type: □ ODJFS	**Funding Type: □ Private Pay**
Eligibility effective date:	
Parent approved schedule: □ M □ T □ W □ Th □ F	
Monthly co-pay amount:	

PRIVATE PAY CLIENTS

Care Level: ☐ 0 to 1-yr-old ☐ 1- to 2-yrs-old ☐ 2- to 3-yrs-old ☐ 3- to 5-yrs-old ☐ 6- to 9-yrs-old ☐ Blended Preschool ☐ Blended School-age

Child's Schedule Effective Date: _____ *Two weeks advance notice needed for changes*

Full-time (FT) Part-time (PT)	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Week 1: _____					
Week 2: _____					
Week 3: _____					
Week 4: _____					

FT = 5 or more hours a day PT = less than 5 hours a day Note: Payments are due each Monday, some months may have 5 weeks

Average anticipated full-time weekly cost of care (based on four weeks shown above _____ Full-time
Average anticipated part-time weekly cost of care (based on four weeks shown above _____ Part-time
Average anticipated blended weekly cost of care (based on four weeks shown above _____ Blended
_____ PARENT'S/GUARDIAN'S INITIALS

Prepay discounts of 9% are offered for two-week advanced payment.

ATTENDANCE POLICY

Children benefit most from our educational programs if attendance is consistent. Their day at Brightside Academy should begin no later than 9:00 a.m. – when we start the day's learning plans. If arriving later than a regularly scheduled time, please contact the academy to ensure proper staff is kept on site to accommodate your arrival. Families with funded care should utilize the maximum number of hours/days allowed under their plan.

Tardiness: Late arrivals are disruptive to the learning process. All instruction begins promptly at 9:00 a.m.

Absences: Please call the academy one hour before your child(ren)'s scheduled arrival time or by 9:00 a.m. to notify the academy director/academy management on each day your child(ren) will be absent. Only 10 absent days are allowed per six months of attendance as stated by ODJFS. After 10 absent days, children will be dropped from the program. Brightside Academy reserves the right to suspend or terminate services for sporadic attendance incongruent with contracted days.

Vacation: Brightside Academy requires that you notify your academy of vacation dates at least two weeks in advance. Any absence occurred during a "vacation" is reported to the funding agency as a non-attended day and will count against the allotted absent days governed by the state.

Parent/Guardian Acknowledgment: I acknowledge that I understand and agree: 1) I received a copy of the attendance policy; 2) I have read, understand and agree to comply with said policy; 3) I understand that failure to do so may result in termination of my child's eligibility/enrollment.
_____PARENT'S/GUARDIAN'S INITIALS

All clients must give a 10-day advance notice of withdrawal of services or those days will be invoiced as attended.

Parent's/Guardian's Signature _____ Date

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

Brightside Academy Ohio 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 Brightside Academy Ohio'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.

Brightside Academy Ohio (Corporate Office)

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

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s)

Date of Permission *(valid for one year)*

Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*

During this trip children will have access to water that is 18 inches or more in depth.
☐ Yes ☐ No

Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☐ No
(if yes, a swimming permission slip is required)

Child's Information

Child's Name

My child is
☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"

Signature

I grant permission for my child to participate in the routine trips described above.

Parent's Signature	Date

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

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

If you answered yes, please indicate which number(s) 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	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

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

If you answered yes, please indicate which number(s) 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 within one hour of the center/home, 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 Food Supplements

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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care 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, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

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**.**
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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 and 5101:2-13-15. 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

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent)**.**

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional

Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		

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 Brightside Academy Ohio! 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.

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

- o 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: _____

Brightside Academy offers a *Getting to Know You* to all new families within 45 days of enrollment. The meeting covers 1) Brightside 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 Brightside 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 Brightside Academy to know to provide the best possible care for your child.

CHILD INFORMATION The section provides Brightside 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 Brightside Academy to know to provide the best possible care for your child.

CHILD WITH SPECIAL NEEDS INFORMATION The section provides Brightside 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 Brightside Academy to know to provide the best possible care for your child.

EARLY EDUCATION AND CHILD CARE
Brightside™
ACADEMY

Photo/Video Release Form

Brightside 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 Brightside 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 Brightside 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 Brightside Academy for any Brightside 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 Brightside 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, Brightside 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 Brightside 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: _____

EARLY EDUCATION AND CHILD CARE
Brightside ACADEMY

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 Brightside 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 Brightside 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: _____

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT

INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2020-2021

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 **Brightside Academy Ohio - Broadway**

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)
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: 7/1/2020

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**, 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.

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, 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 INCOME ELIGIBILITY GUIDELINES
Guidelines to be effective from July 1, 2020 through June 30, 2021
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	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add	+8,288	+691	+346	+319	+160

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.

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CACFP
INFANT MEALS – PARENT PREFERENCE LETTER

TO: **Parents and Guardians of Infants under one year of age**

FROM:

Name of Center or Provider	Brightside Academy Ohio, LLC.

TOPIC: **Who will provide food for your infant's meals?**

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a child nutrition program of the United States Department of Agriculture. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

Center or provider to insert the NAME OF FORMULA that they will provide	Gerber Gentle , Gerber Soothe, Gerber Soy

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section.

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

☐ I want the center or FCC home provider to provide formula for my infant

☐ I will bring iron fortified infant formula for my infant

Parent/Guardian: List Name of Formula You Will Provide

☐ I will bring expressed breast milk for my infant

☐ I will come to the center or FCC home to breast feed my infant

Solid Food: (check one)

☐ I want the center or FCC home to provide solid food for my infant when he/she is developmentally ready for it

☐ I will bring solid food for my infant when he/she is developmentally ready for it

***Note: If your feeding preferences change, the center or provider will ask you to complete a new form.**

INFANT'S NAME:	**INFANT'S BIRTHDATE:**
PARENT/GUARDIAN SIGNATURE:	**DATE:**

USDA INCOME ELIGIBILITY GUIDELINES
Fiscal Year 2020
Effective July 1, 2019 through June 30, 2020

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

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

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/participant.

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups)
Milk Fruit or Vegetable Grain Meat/meat alternate (may be substituted for the grain up to 3 times per week)	Milk Meat/meat alternate Grain Vegetable (two different vegetables can be substituted for a fruit) Fruit	Milk Meat/meat alternate Grain Vegetable Fruit

Participating Facilities

Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed private homes.
- **After School Care Programs**: Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information

If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Susan Frazier
300 Martin Luther King Jr. Dr.
Toledo, Ohio 43604
(216) 313-8205
sfrazier@brightsideohio.com

Ohio Department of Education

CACFP Program Specialist
25 S. Front Street, MS 303
Columbus, OH 43215-4183
Phone: 614-466-2945
Toll Free: 1-800-808-6235

Nondiscrimination

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.

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What Do I Bring to My First Visit?

- Proof of income (current pay stubs, approval letter for Healthy Start, Ohio Works First, Food Stamps or current Medicaid card)

- Proof of address (utility or credit bill, or Ohio driver's license)
- Proof of identity for you and any other applicants (birth certificate, driver's license, Medicaid card, crib card or shot record)
- All family members applying for WIC services
- If pregnant, a doctor's statement showing due date
- Children's shot records

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

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Healthy Ohio
The State of Living Well.

The mission of the WIC program is to improve the health status and prevent health problems among Ohio's at-risk women, infants and children.

Visit our Web site: http://www.odh.ohio.gov

0700.13

Eat Smart, Play Hard

What is WIC?

WIC is a nutrition education program. WIC provides nutritious foods that promote good health for pregnant women, women who just had a baby, breastfeeding moms, infants and children up to age 5.

Who is Eligible For WIC?

Women who are pregnant, breastfeeding or have a baby less than 6 months old, and infants and children up to 5 years old are eligible to apply for WIC. Fathers are welcome to apply for WIC for their children up to age 5.

To qualify for services you must:

- ♥ Live in Ohio
- ♥ Meet WIC income guidelines
- ♥ Have certain nutritional or health risks

What Does WIC Provide?

- ♥ Nutrition education and support
- ♥ Breastfeeding education and support
- ♥ Referral for health care
- ♥ Immunization screening and referral
- ♥ Supplemental foods such as:
  - Cereal
  - Eggs
  - Milk
  - Whole-grain foods
  - Fruits and Vegetables
  - Infant formula

How Do I Apply?

Make an appointment

Call your local clinic to schedule an appointment to meet with a WIC staff member or call **1-800-755-GROW (4769)** for locations and more information.

See if you qualify

All it takes is a visit to your local WIC clinic to see if you qualify for services.

Receive WIC coupons

If you are eligible, you will receive coupons to buy healthy foods at local WIC-approved grocery stores.

- Determined by health professionals to be at medical/nutritional risk; and
- Meets income guidelines - 185 percent of Federal Poverty Income Guidelines.

Ohio WIC Program Income Guidelines

In order to be eligible for WIC, the gross countable income of the economic unit, of which the applicant/participant is a member, must be less than or equal to the Ohio WIC program income guidelines for economic unit size provided in the following chart. WIC income guidelines are updated each year.

Economic Unit	Annually	Monthly	Twice Monthly	Biweekly	Weekly
1	$22,459	$1,872	$936	$864	$432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508

(Revised July, 2018)

How To Apply

WIC clinics are located in all 88 Ohio counties. Applicants can call the Help Me Grow Helpline at **1-800-755-GROW (1-800-755-4769)** for specific clinic locations or call your county WIC clinic **(see WIC Clinic Directory button on the first page for your county WIC clinic phone number).**

You can also apply by printing out a WIC Program Application (Solicitud del Programa de WIC) and mailing it to the WIC clinic in your area. Please note that you must schedule an appointment at the clinic, too.

To save time at your appointment, you can also print out a health history form from the list below. Print out one health history form for each person applying. Be sure to complete the form that best describes the person: 1. infant (birth to 12 months old), 2. child (age 1 to 5 years), 3. pregnant, or 4. breastfeeding woman or woman who has had a baby in the last 6 months and is not pregnant. The WIC staff will help you to make sure you receive health and nutrition information that is individualized to you and your family based on the information on these completed forms.

1. WIC Health History for Infants

   Historial de Salud de WIC para Infantes

2. WIC Health History for Children

   Historial de Salud para Niños de 1 hasta 5 Años

3. WIC Health History for Pregnant Women

   Historial de Salud de WIC para Mujeres Embarazadas

4. WIC Health History for Breastfeeding and Postpartum Women

   Historial de Salud de WIC para Mujures Lactando/Amamantando o en Postparto

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.