ENROLLMENT APPLICATION

Kiddies Daycare will operate from
Monday – Friday 7:00am-5:00pm
Please specify the hours and days your child will attend.

CHILD	Name of Child	
	Date of Birth	
	Home Address	

Please keep phone numbers and addresses updated with your child's school.

		Mother/Guardian		Father/Guardian
PARENT	Name		Name	
	Date of Birth		Date of Birth	
	Home Phone		Home Phone	
	Cellular		Cellular	
	Home Address		Home Address	

		Mother/Guardian		Father/Guardian
WORK	Business Name		Business Name	
	Business Phone		Business Phone	
	Address		Address	

Please write contact other than parents that is a valid telephone number.

Persons authorized to pick up your child and/or contact in case of emergency if neither parent/guardian is available to assume responsibility for the child.				
EMERGENCY	Name of Contact #1		Name of Contact #2	
	Home Phone		Home Phone	
	Cellular		Cellular	
	Relationship		Relationship	
	Address		Address	

WALKS	10:122-6.8 Parent and community participation May be signed by parents to authorize walking trip participation. ___ I give my permission for my child to participate in walking trips within the center's Neighborhood and to the local park. ___ I do not give my permission for my child to participate in walking trips within the center's Neighborhood and to the local park. I understand that the walking route includes no safety hazards and that the walks will not involve entrance into any facility other than the following: _____ _____ _____ Parent's/Guardian's Signature: _____ Date: _____

CUSTODY	If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the child, please explain below and **attach a copy of appropriate court order.** Name of person PROHIBITED from picking up the child: _____ _____ Name Date

POLICIES	I (we) attest that all the information on this application is accurate, and that I (we) have received the following information for my (our) home records: 1. Information to Parents Document 2. Policy on the Release of Children 3. Philosophy of Discipline 4.Policy on the Management of Illness/ Communicable Diseases 5. Expulsion Policy Parent's Signature/Guardian(s):_____Date _____
EMERGENCY	I understand that if my child becomes ill, and care is necessary, the school shall make every effort to contact me and/or another person herein designated by me. Upon failure to contact my designee, or me or if any emergency requires immediate attention, I hereby authorize the school to appropriate and necessary care. If your child develops a fever during the time, he/she is at the center, you will be contacted immediately and have 1 hour to pick up your child. I have completed the medical emergency permission form, which authorizes the center to seek emergency medical care for my child as deemed necessary by the director or the director's designee. Parent's Signature/Guardian:_____Date: _____
DEMOGRAPHICS	Racial and Ethnic Information This information is collected for state and federal reporting only. It is voluntary and will **not** affect your child's enrollment or participation in our program. Ethnicity (select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer Race (select all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer not to answer Parent/Guardian Signature: _____ Date: _____

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Child's Name _____Date of Birth _____ Age_____

Parent's/Guardian's Name_____

Parent's/Guardian's Address_____

Home Telephone _____Cellular _____

CHILD'S MEDICAL INFORMATION

Medical Problems _____

Allergies _____Medicine(s) Child is taking _____

Name of Child's Doctor_____Telephone_____

CHILD'S INSURANCE COMPANY/HMO_____

Group Number_____Identification # _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct, we authorize Kiddies Daycare director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

<u>The following steps will be followed in an emergency:</u>

1. The parents/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact you through all the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all the following:
    (a) Call for emergency first aid assistance/transportation.
    (b) Call another physician.
    (c) Have the child transported to an emergency hospital in the company of a staff member.

Parent Signature: _____ Date of Signature: _____

COVER LETTER FOR DYFS INFORMATION TO PARENTS DOCUMENT

Dear Parents:

In keeping with New Jersey's Childcare Center Licensing Requirements, we are required to provide you, as the parent of a child enrolled in our center, with this informational statement. The statement highlights, among other things: your right to visit and observe our center with out having to secure prior permission; the center's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Division of Youth and Family Services (DYFS).

Please read this statement carefully and, if you have any questions, feel free to contact us at: (908) 759-0123.

Sincerely,

Kiddies Daycare Management

Name of Child:

_____

Name of Parent(s)/Guardian(s):

_____

I have read and received a copy of the Information to Parents documents prepared by the Bureau of Licensing in the Division of Youth and Family Services.

Signature: _____ Date: _____

Agreement between Parent and Kiddies Daycare

I understand that I am the person responsible for picking up my child. If I am not able to pick my child up from the center, I will inform the center of another adult that will be responsible for picking up my child from the center. I understand that this person must be at least 18 years of age or older.

Initials _____

I have provided the center with 2 or more emergency contacts (friends or relatives) in case I am not available to care for my child in case of any emergency. As well as my own updated home, job and cell phone numbers.

Initials_____

I understand that when my child has an accident at home, I will inform the center. I agree to call the center if my child is sick and is going to be late or absent. I will provide a doctors note when my child is sick and has been absent for three days or more.

Initials _____

I understand that if my child is picked up after 5:00p.m, a late fee of $1.00 per minute will be enforced and must be paid within that week.

Initials_____

10:122-6.8 Expulsion Policy
May be used to inform parents of the center's policy on the expulsion of children from enrollment.

Expulsion Policy

NAME OF CENTER: Kiddies Daycare

NAME OF CHILD: _____

SIGNATURE OF PARENT: _____

Unfortunately, there are sometimes reasons we must expel a child from our program either on a short term or permanent basis. We want you to know we will do everything possible to work with the family of the child(ren) to prevent this policy from being enforced. The following are reasons we may have to expel or suspend a child from this center:

IMMEDIATE CAUSES FOR EXPULSION:

- The child is at risk of causing serious injury to other children or himself/herself.
- Parent threatens physical or intimidating actions toward staff members.
- Parent exhibits verbal abuse to staff in front of enrolled children.

PARENTAL ACTIONS FOR CHILD'S EXPULSION:

- Failure to pay/habitual lateness in payments.
- Failure to complete required forms including the child's immunization records.
- Habitual tardiness when picking up your child.
- Verbal abuse to staff.
- Other (explain)_____

CHILD'S ACTIONS FOR EXPULSION

- Failure of child to adjust after reasonable amount of time.
- Uncontrollable tantrums/ angry outbursts
- Ongoing physical or verbal abuse to staff or other children
- Excessive biting
- Other (explain)_____

SCHEDULE OF EXPULSION:

- If after the remedial actions above have not worked, the child's parent/guardian will be advised verbally and in writing about the child's or parent's behavior warranting an expulsion. An expulsion action is meant to be a period so that the

- parent /guardian may work on the child's behavior or to come to an agreement with the center.
- The parent/ guardian will be informed regarding the length of the expulsion period.
- The parent/guardian will be informed about the expected behavioral changes required for the child or parent to return to the center.
- The parent/guardian will be given a specific expulsion date that allows the parent sufficient time to seek alternate childcare (approximately two weeks' notice depending on risk to other children's welfare or safety).
- Failure of the child/parent to satisfy the terms of the plan may result in permanent expulsion from the center.

A CHILD WILL NOT BE EXPELLED

If a child's parent(s):

- Made a complaint to the office of licensing regarding a center alleged violations of the licensing requirements.
- Reported abuse or neglect occurring at the center.
- Questioned the center regarding policies and procedures.

Without giving the parent time to make other childcare arrangements.

PROACTIVE ACTIONS THAT CAN BE TAKEN IN ORDER TO PREVENT EXPULSION

- Staff will try to redirect child from negative behavior.
- Staff will reassess classroom environment, appropriate activities, supervision.
- Staff will always use positive methods and language while disciplining children.
- Staff will praise appropriate behaviors.
- Staff will consistently apply consequences for rules Child will be given verbal warnings.
- Child will be given time to regain control.
- Child's disruptive behavior will be documented and maintained in confidentiality.
- Parent/guardian will be notified verbally.
- Parent/guardian will be given written copies of the disruptive behavior that might lead to expulsion.
- The director, classroom staff and parent/guardian will have a conference to discuss how to promote positive behaviors.
- The parent will be given literature or other resources regarding methods of improving behavior.
- Recommendation of evaluation by professional consultation on premises
- Recommendation of evaluation by local school district child study team

Source: Medication Administration in Childcare, Healthy Childcare New Jersey

PERMISSION TO GIVE MEDICATION IN CHILDCARE

(Please use one form per medication)

10:122—7.5 Administration and control of prescription and non-prescription medicines and health care procedures. May be used to record permission for administration of medication children.

INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE

Name of Child_____

Child's condition for administering medication:

_____cold _____sore throat _____rash _____ear infection _____teething

_____injury _____ other _____

Name of medication/procedure_____

_____Prescription _____Non-prescription _____ Doctor's approval required.

Amount to be administered _____

Time(s) to be administered _____

Dates to be administered from _____ to _____

Refrigeration necessary Yes _____ No _____

Refrigeration necessary Yes _____ No _____

Special instructions

_____

Possible adverse reactions

_____

I authorize the administration of medication to my child.

_____ Date_____

Parents Signature

* Is all the above information complete? *Has the medication been placed out of reach of children? *Is the medication in the original container with the prescription label on it? * Is the child's name on the container? * Is the date of medication updated?

Dates Administered	Times Administered	Adverse reactions observed	Staff members initials

Kiddies Daycare

Food Allergy/Intolerance Information Sheet

Child's Name_____ Grade___ PS___

Current Food Course_____

Food Allergy

Parents – Please Initial:

_____My child has a food allergy. Please complete additional questions below.

_____My child does NOT have a food allergy.

Please indicate which food/s your child is allergic to. Check all that apply.

☐ Tree nuts ☐ Wheat

☐ Peanuts ☐ Eggs

☐ Dairy ☐ Gluten

☐ Other_____

Please indicate which method/s of contact cause a reaction. Check all that apply.

☐ Inhalation (air borne)

☐ Ingestion

☐ Touch

This statement is to verify that I have read/viewed each item in its entirety and have completed this form in regards to my child's food allergies/intolerances.

Print Parent/Guardian Name_____ Date_____

Parent/Guardian Signature_____

Social Media Policy for Parents:

We at Kiddies Daycare value your and your child's privacy. The following is different circumstances in which your child's picture would be taken, given your consent. Please sign if you consent. *If no signature is given, no photos of your child will be taken.*

Here at Kiddies Daycare we like to decorate and personalize the classrooms, which includes labeling your child's crib and cubby with their name and picture. I consent to my child's photo being taken and presented in the classroom.

Signature_____ Date_____

Our facility uses ClassDojo, a classroom app that allows us to upload photos and messages to parents throughout the day, ensuring parents get constant updates on their child's wellbeing and progress. I consent to my child being photographed for the exclusive use of ClassDojo.

Signature_____ Date_____

Our Instagram account is @kiddies.daycare and our Facebook account is Kiddies Daycare. I consent to the uploading of my child's image on the Kiddies Daycare public accounts.

Signature_____ Date_____

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

2026 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM
ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT(S)

(Name) *(Age)* *(Name)* *(Age)*

OPTIONAL: *RACIAL/ETHNIC IDENTITY OF PARTICIPANT*

Check one ETHNIC identity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Mark one or more RACIAL identity (ies):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

Enrollment Information

Check (✓) each day *the above participant is enrolled for care, the* ***hours of care*** *each day, and the* ***meal type(s)*** *served:*

	☐ *MON*	☐ *TUES*	☐ *WED*	☐ *THURS*	☐ *FRI*	☐ *SAT*	☐ *SUN*
DAYS OF CARE:							
HOURS OF CARE:	___-___	___-___	___-___	___-___	___-___	___-___	___-___
Swing / Rotating Shifts: (If Applicable)	___-___	___-___	___-___	___-___	___-___	___-___	___-___

MEAL TYPES SERVED: ☐ ***BREAKFAST*** ☐ ***A.M. SUPPLEMENT*** ☐ ***LUNCH*** ☐ ***P.M. SUPPLEMENT*** ☐ ***DINNER***

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: **BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP)** *(formerly Food Stamps)*, **Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)**

If you are now receiving SNAP,TANF or FDPIR for this child, complete **one** of the following numbers:

SNAP CASE #_____ *OR* TANF CASE #_____ *OR* FDPIR CASE #_____

OPTION 1B: **FOSTER CHILD**

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

☐ **FOSTER CHILD** **INCOME $**_____

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: **BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid**

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete **one** of the following numbers:

SNAP #_____ *OR* FDPIR CASE #_____ *OR* SSI CASE #_____ OR MEDICAID CASE #_____

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (*Related and Unrelated*)	MONTHLY INCOME *(Complete One Or More - Before Deductions)*				
	Monthly (Gross Earnings) Wages/Salary	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WORKER'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	Monthly Any Others Income
1.	$	$	$	$	$
2.	$	$	$	$	$
3.	$	$	$	$	$
4.	$	$	$	$	$
5.	$	$	$	$	$
6.	$	$	$	$	$
7.	$	$	$	$	$
8.	$	$	$	$	$
9.	$	$	$	$	$
10.	$	$	$	$	$
TOTAL NUMBER IN HOUSEHOLD ***(INCLUDE ENROLLED PARTICIPANT):*** _____					
TOTAL GROSS HOUSEHOLD INCOME:				$ _____	

ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: ***(See Privacy Act Statement below)***

An Adult Household Member must sign and date this form and list the last four (4) digits of his or her Social Security Number.

If you do not have a social security number, mark the box - ☒ I do not have a Social Security Number".

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that a income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information, and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. ***An Adult Household Member must complete the following:***

Signature: _____ Address: _____

Print Name: _____ City: _____ State: _____ Zip Code: _____

Date: _____ Phone Number: _____

Last four (4) digits of Social Security Number: * * * - * * * - _____ ☐ **I do not have a Social Security Number**

PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, and investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

Determination: Free _____ Reduced _____ Paid _____

Signature of Determining Official:

_____ Date_____

TOTAL MONTHLY INCOME $_____

Conversion factors to figure monthly income: Weekly x 4.33

Twice a month x 2

Every 2 weeks x 2.15

2025-2026 CHILD AND ADULT CARE FOOD PROGRAM LETTER TO PARENT/PARTICIPANT

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.

The income that you report must be the total gross income received by all members of your household.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced- priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. ***fax:***
   (833) 256-1665 or (202) 690-7442; or
3. ***email:***
   program.intake@usda.gov

This institution is an equal opportunity provider.

Kiddies Daycare LLC (908) 759-0123

(Name of Day Care Center) ***(Day Care Center Phone Number)***

New Jersey Department of Agriculture Child and Adult Care Food Program ***Phone Number 609-984-1250***

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant *(First and Last Names).*
2. Complete the Days, Hours of Care, and the meal types served to the enrolled participant. *(One time requirement for Adult Day Care participants.)*

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by the agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.

b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY:

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

3. Names of all *(Related or Unrelated)* household members
4. List the household income *(Monthly Gross Earnings)* for each household member.
5. Total number in household *(1 + #3 above)*.
6. Total the gross income of all household members.
7. Sign, Print and complete the full address of the Adult Household Member signing the application.
8. Date the form and complete the telephone number of Adult Household Member signing the application.
9. List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE - Effective From July 1, 2025 to June 30, 2026

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	$20,346 - $28,953	$1,697 - $2,413	$ 393 - $ 557
2	$27,496 - $39,128	$2,293 - $3,261	$ 530 $ 753
3	$36,646 - $49,303	$2,889 - $4,109	$ 668 - $ 949
4	$41,796 - $59,478	$3,484 - $4,957	$ 805 - $1,144
5	$48,946 - $69,653	$4,080 - $5,805	$ 943 - $1,340
6	$56,096 - $79,828	$4,676 - $6,653	$1,080 - $1,536
7	$63,246- $90,003	$5,272 - $7,501	$1,218 - $1,731
8	$70,396 - $100,178	$5,868 - $8,349	$1,355 - $1,927
Each Additional Family Member	**+10,175**	**+848**	**+196**

Please be sure to bring the following forms as soon as possible:

1. Enrollment Application
2. Parent's picture ID
3. Proof of Address (PSEG, telephone bill, cable bill, or bank statement)
4. Child's Birth Certificate
5. Immunization Record/ Physical
6. Universal Child Health Record completed by child's physician
7. CCCC Application

Por Favor asegúrese de traer las siguientes formas lo más pronto posible:

1. Aplicación de registro
2. Identificación con fotografía de los padres
3. Prueba de dirección (PSEG, cuenta de teléfono, cuenta de cable, o carta de banco)
4. Certificado de nacimiento del niño/a
5. Certificado de Vacunas/ Fisico
6. Registro Universal de Salud Infantil completado por el médico del niño
7. Aplicación de CCCC