EDNA MARTIN
CHRISTIAN CENTER

Dear Parent/Guardian,

On behalf of the Board and staff of the Edna Martin Christian Center, it is our pleasure to welcome you and your child into the School Aged Youth Program. There can be no more important investment than the decision you make regarding your child's education, and we are grateful that you have chosen EMCC as your option.

A 76 year-old institution, EMCC has historically been a safe haven for family empowerment, with a particular focus on our youth. In recent years, we have striven to enhance that commitment by introducing high quality educational programming and staff to ensure all students gain the academic and social supports necessary to compete globally. Our children are an invaluable asset to the well being of our community as a whole. We recognize their early experiences will play a vital role in determining their direction in life. That's why the core focus of each of our programs is developing children socially, spiritually, emotionally, intellectually, and physically.

Specifically, our programs offer research based academic practices that are consistent with state and national education standards. We supplement this instruction with faith-based character development exercises, elective activities and service learning opportunities in the effort to develop leaders that will in turn give back to the community as successful adults. We take pride in the fact that our entire youth serving staff are carefully vetted, rigorously trained, and routinely evaluated to ensure the best possible care for your child.

We look forward to serving you and maintaining a strong and rewarding relationship with your family. If there is anything you need from us, please don't hesitate to ask.

Sincerely,

Edna Martin Christian Center
Leadership & Legacy Program Staff

EMCC Enrollment Checklist

(Below are the items we need in order for you to be enrolled in our program. Registration will occur annually.)

- **All Programs and Services must turn in** a signed and completed registration packet, including the parent/policy agreement form and all paperwork pertaining to the CACFP food program before beginning any EMCC youth program.

All Programs and Services

(*This includes Martindale-Brightwood Family Stability Project families, full week paid programming families, and CCDF receiving families.)*

____ Registration Packet with appropriate signatures
____ Registration fee of **$25.00**
____ Parent's Notice
____ Transportation Policy
____ Discipline Policy
____ Scholarship Contract
____ Safety Plan Acceptance
____ Emergency Contacts with Phone Numbers
____ Emergency Authorization for Pick Up
____ Up-to-date shot records (immunizations) and physical completed by a physician's office (**MUST HAVE THE FIRST DAY OF ATTENDANCE!)**
____ Payment for first week
____CCDF Approval letter *(if a receiving CCDF vouchers)*
____Proof of income *(CDBG)*

_____ALL DOCUMENTS RECEIVED AND COMPLETE

Date: _____ **Staff Signature**: _____

EDNA MARTIN CHRISTIAN CENTER

EMCC Registration Form

(This information must be filled out entirely.)

Staff Use Only:
School: _____
Site: _____
Grade: _____

Child's Name: _____ Start Date: _____ Birth Date: _____/_____/_____

Child's Name: _____ Start Date: _____ Birth Date: _____/_____/_____

Child's Name: _____ Start Date: _____ Birth Date: _____/_____/_____

Child's Name: _____ Start Date: _____ Birth Date: _____/_____/_____

Child's Name: _____ Start Date: _____ Birth Date: _____/_____/_____

Parent Information

Parent Name(s)_____

Home Address_____ Zipcode_____

Home Phone #_____ Cell Phone #_____

Work Phone #_____ Company Name_____

Parent Date of Birth _____ Gender_____

***Email address that will be checked frequently and can be used for home/center communication:**

_____

Emergency Contacts

****Emergency Contact Persons: (Will be contacted in case of emergency when parent can not be reached)**

Name: _____ Phone #: _____ Relationship to child: _____

Name: _____ Phone#: _____Relationship to child: _____

Authorized to pick up list

(We will ONLY release your child to the people listed below. Please have ID, as it will be checked)

Name: _____ Home #: _____ Cell #: _____

Name: _____ Home #: _____ Cell #: _____

Name: _____ Home #: _____ Cell #: _____

Name: _____ Home #: _____ Cell #: _____

***If there is anyone prohibited by court order, from having contact with your child, their names must be listed below and we must have the order on file.**

Name: _____ Name: _____

Household Information

Custodial Parent/Guardian Full Name: _____

Relationship to student: _____

Marital Status (check one):

___Common Law ___Divorced ___Single
___Domestic Partner ___Married
___Separated ___Widowed

Race (check all that apply):

___African American ___Asian ___Multi-Racial
___Bi-Racial ___Caucasian ___Native American
___Hawaiian/Pacific Islander ___Hispanic Other: _____

- Do you currently receive any housing assistance *(i.e. Section 8, Subsidized or income-based housing)?* If yes, which type? _____
- Does your child(ren) receive Free/Reduced Lunch? **YES** **NO**
- Total Number of People in the Household: _____
- Approximate Annual Household Income: $_____
- Parent's Place of Employment: _____
    - Annual Salary: $_____

Household Member (first name, last name)	***Position in Family (parent, sibling, cousin, etc.)***	***Age***

Additional Income Sources (check all that apply):

___Employment Earnings ___Child Support ___TANF
___Interest/Dividends ___Veterans Benefits ___Unemployment
___Pension/Retirement ___Self Employment Income ___Other Income
___Social Security ___ Supplemental Security Income (SSI)

Getting To Know Your Child Form

Child's Name: _____Nickname: _____ D.O.B. _____/_____/_____

Gender: _____ Race: _____Shirt size_____ Pants/Skirt Size: _____

Current Age: _____ Grade: _____ School Attending: _____

Teacher: _____ Classroom #: _____ Favorite Color: _____

Child resides with [circle one] – Mother – Father – Both Parents – Grandparents – Other: _____

Any Known Allergies (food or other)? _____

Any Special Needs or Medical Conditions? _____
_____

Does your child have any special fears/phobias?_____

Authorization for School Pick up/Release

Student's name: _____ Grade: _____ D.O.B. ___/____/_____ School_____
Student's name: _____ Grade: _____ D.O.B. ___/____/_____ School_____
Student's name: _____ Grade: _____ D.O.B. ___/____/_____ School_____
Student's name: _____ Grade: _____ D.O.B. ___/____/_____ School_____
Student's name: _____ Grade: _____ D.O.B. ___/____/_____ School_____

School Pick up:

- By signing below, I request & authorize the Edna Martin Christian Center to pick up my child(ren) upon school dismissal and/or for related activities that may occur during year round youth programming.

Parent Signature_____ Date_____/_____/_____

Field Trip & Transportation Waiver

- I hereby give permission for my child to attend fieldtrips and other excursions offered as a part of this program. I understand the children will be transported in a motor vehicle and agree to hold harmless the Edna Martin Christian Center, their agents, officers, employees, and volunteers, from any and all liability, claims, suits, demands, judgment costs, interest and expense (including attorney's fees and costs) arising from such activities, including any accident or injury to the student and the cost of medical service.

Parent Signature: _____ Printed Name: _____
Date: _____ Children enrolled: _____
EMCC Staff Signature _____ Date: _____

Photo Release/Waiver

- I hereby give my consent without further consideration to allow the Edna Martin Childcare Ministry or its designated agent to take pictures/video of my child for use in things such as classroom activities, publication, and broadcast media for advertisement purposes. I also understand that EMCM staff agrees not to use my child's pictures for personal use such as social media sites i.e. Facebook or Instagram.

Parent Signature: _____Printed Name: _____
Date: _____/_____/_____ Children enrolled: _____
EMCC Staff Signature: _____ Date: _____/_____/_____

Authorized Medical Release & Liability

- I hereby agree not to hold Edna Martin Christian Center responsible for any illness or injury which may occur during normal activities of my child's time at EMCC. In the case of an accident and medical attention is required, I understand that all efforts will be made to contact the parent first. In the incident where I and my emergency contacts may not be reached, and it is deemed that my child needs medical attention from a physician, I give permission for EMCC to transport or have an ambulance transport my child to the nearest hospital to be treated by a physician. I further grant the facility and its staff, to render lifesaving medical care such as CPR and first aid to my child. I also agree to resume financial responsibility for any medical treatment my child needs.

Known Allergies: _____

Dr.'s Name: _____ Dr's. Phone #: _____

Name of Insurance: _____ Policy #: _____

Parent Signature: _____ Printed Name: _____

Date: _____/_____/_____

"Small Blessings" Scholarship Form

I, _____, understand that the Edna Martin Christian Center Leadership & Legacy Program has a standard weekly rate in order to attend the program. I understand that I qualify for the "Small Blessings" scholarship in which a portion of my child's weekly rate will be paid. I understand that the scholarship is available for the duration of the school year or summer program, whichever is applicable. I understand that I will need to reapply and my weekly fee may increase to allow monies to continue to be available for all families in need. I also understand that as a recipient of the scholarship award, my weekly rate must be paid on time by Friday afternoon, prior to the week of attendance.

My weekly rate with scholarship is: _____

- *By signing below I agree to the terms and conditions of the Small Blessing Scholarship agreement as written above.*

Parent Signature: _____ Date: _____/_____/_____

Authorization to Use and/or Disclose Protected Health & Educational Information

- **I hereby authorize the Edna Martin Christian Center to use and/or disclose educational and/or protected health information regarding my child.**

Parent's initials _____

Student's Name: _____ D.O.B._____ Grade: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ School Attending: _____

Printed Parent Name: _____ Email: _____

- **I hereby request & authorize my child's school district to furnish and all pertinent information related to attendance, discipline reports, grade reports, and testing results, including written and electronic information for the student listed above to the Edna Martin Christian Center**

- **I also hereby request & authorize the Edna Martin Christian Center to furnish to _____(school name), any and all pertinent school data, including verbal Communication for the student listed above for each of the following reports:**

Attendance reports	Medical Files	Case conference reports/IEP's
Multidisciplinary Evaluation	Team reports	Psychological Evaluation reports
Grade Reports/Testing reports	Discipline reports	Immunization Records

- **I hereby request & authorize _____ (school name), to verbally communicate with and/or furnish any and all of the above files to the Edna Martin Christian Center.**
  This information will be used to develop an educational program for the student(s) listed above. This authorization may be revoked at any time by the undersigned by giving written notice to the center. Revocation of this authorization will not affect any action taken in reliance on this authorization before your school's receipt of the notice of revocation. By authorizing disclosure of the student's health information in accordance with this authorization, the student's health information may be further disclosed and may no longer be protected by Federal health information privacy laws.
  This authorization will expire at the conclusion of the student's tenure at the Edna Martin Christian Center.

  Parent Signature_____ Date_____

Thank you to our sponsors:

Discipline Policy

It is very important that a child's development is nurtured through caring, patience, and understanding. In order to maintain a positive, supportive culture at Leadership & Legacy, parents, children, and EMCC staff all must participate.

However, while caring for your children, we may have to respond to your child's misbehavior. Hitting, kicking, spitting, cursing, stealing, fighting, hostile verbal behavior, failing to follow directions, and other behaviors that will hurt someone else are NOT permitted.

In response to these behaviors, *we will not:*

- Use threats or bribes
- Use physical punishment, even if requested by the parent
- Deprive your child of food or other basic needs
- Use humiliation or isolation

In response to misbehaviors, *we will:*

- Respect your child
- Establish clear rules
- Be consistent in enforcing rules
- Use positive language to explain desired behavior
- Speak calmly while bending down to the child's eye level
- Give clear choices
- Redirect your child to a new activity or separate them from the problem
- Move your child to a time-out chair for no longer than one minute per year of your child's age, if necessary
- Inform parents proactively about behavior issues

If your child's behavior is very disruptive or harmful to himself or the other children, we will discuss the issue with you privately. If this situation can be resolved the child will remain enrolled. If we are unable to resolve the issue, we reserve the right to dismiss your child from our program.

- *By signing below, I agree that I have read and agree to abide by the EMCC Leadership & Legacy Program Discipline Policy as listed above:*

Parent Signature:_____ Date: _____/_____/_____

Names of Child/Children enrolled:_____

Drop-off/Pick-up and Home Transportation Policy

Before Care/Drop-off:

- Leadership & Legacy doors open at 7am.

- **Parents must come inside the building and sign-in students when they arrive**. There will be no exceptions to this policy. When a parent signs a child in, this acknowledges that the child is now under the care and supervision of EMCC and remains EMCC's responsibility until taken to school.

After Care/Pick-up:

- Leadership & Legacy doors close at 6pm.

- **All students must be picked-up no later than 6pm.** If a parent is late without prior notification, the family will be charged $1 per minute after 6pm.

- **Parents must come inside to sign-out their child at the end of the program day.** There will be no exceptions to this policy. This transfers the responsibility of supervising the child from EMCC back to the parent.

- If a parent is unable to pick up their child, the student will ONLY be released to individuals listed on the "authorized to pick up" list on that child's program application form. Staff will ask to see I.D. and verify their name to the student's application, if someone they do not know arrives to pick up a student.

- **Students will not be released to anyone, including parents, who appear to be under the influence of drugs or alcohol. Emergency contacts will be called to transport the child home.**

- If a student becomes ill during the school day, or if an emergency arises where the student must leave school, parents are asked to notify EMCC staff that the child will not be present for the after-school program that day.

Home transportation:

- There are a limited number of seats available for students who need EMCC transportation home at the end of the program day. These seats will be filled based on demonstrated need, so that transportation issues are not a barrier to program participation.
- EMCC transportation is a privilege, not a right. Disruptive behavior on EMCC vehicles will result in expulsion from EMCC transportation.

___ **Yes,** I am in need of EMCC transportation home for my child(ren) at the end of the program day, due to the following circumstances:

_____

_____

___ **No,** I (or someone I authorized on page 3 of this application) will pick up my child(ren) by 6pm, at the end of the program day.

- *By signing below, I certify that I have read and agree to abide by the EMCC Leadership & Legacy Program Drop-off/Pick-up and Home Transportation Policy as listed above.*

Parent Signature: _____ Date:_____/_____/_____

Transportation Policy

As part of our services, the Edna Martin Christian Center will be providing transportation for the students in our care. The Edna Martin Christian Center agrees to follow the following regarding our transportation:

- The Edna Martin Christian Center vehicles are properly plated and insured at all times.
- Any person driving the Edna Martin Christian Center vehicles is at least 18 years of age and holds a valid drivers license.
- The drivers are EMCC employees or volunteers and have therefore met all CCDF Provider Eligibility Standards.
- The Edna Martin Christian Center staff will make sure the children are transported safely and follow proper seatbelt procedures as required by Indiana state law.
- The Edna Martin Christian Center Youth Program will require a permission slip signed by the parent or guardian to keep in each student's file. (Available on page 4 of this packet.)
- The Edna Martin Christian Center will transport our students before and after school, field trips during breaks from school,
- The Edna Martin Christian Center will transport toddler students, pre-school students and school-age students only.

➢ *By signing below, I certify that I have read and agree to the EMCC Leadership & Legacy Program Transportation Policy as listed above.*

Parent Signature: _____ Date: _____/_____/_____

Policy/Parent Handbook Received

➢ By signing below, I certify that I have read and agree to abide by all of Edna Martin Christian Center Leadership and Legacy Program's policies & procedures, as listed in both the Parent Handbook & this Registration Packet. I understand that at times there may need to be an addendum made to the handbook and that I must read and sign that I agree to follow any new policies as well.

Parent/Guardian Signature: _____ Date:_____/_____/_____

Edna Martin Christian Center
Medical Statement for Children with Special Dietary Needs

This statement must be completed and submitted to Edna Martin Childcare Facility before any meal substitutions can be made. The parent/guardian will complete Part 1 and the physician will complete either Part 2 **OR** Part 3. Refer to the information below for clarification. Attach a sheet with additional information if necessary. If changes are needed, the parent/guardian is required to submit a new form signed by the child's physician.

GUIDANCE

Disability:

Under Section 504 of the *Rehabilitation Act of 1973,* and the *Americans with Disabilities Act* (ADA) of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

USDA regulations 7 CFR Part 15b require substitutions or modifications in CACFP meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions in foods when that need is supported by a statement signed by a licensed physician. The physician's statement must identify: the child's disability; an explanation of why the disability restricts the child's diet; the major life activity affected by the disability; the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.

Generally, children with food allergies or intolerances do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA, and food service may, but is not required to, make food substitutions for them. However, when in the licensed physician's assessment, food allergies may result in severe, life-threatening (anaphylactic) reactions, the child's condition would meet the definition of "disability," and the substitutions prescribed by the licensed physician must be made.

Special Dietary Needs That Are Not a Disability:

Food service may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Such determinations are only made on a case-by-case basis. This provision covers those children who have food intolerances or allergies but do not have life-threatening reactions (anaphylactic reactions) when exposed to the food(s) to which they have problems.

Each special dietary request must be supported by a statement, which explains the food substitution that is requested. It must be signed by a recognized medical authority. The medical statement must include: an identification of the medical or other special dietary condition which restricts the child's diet; the food or foods to be omitted from the child's diet; and the food or choice of foods to be substituted.

Recognized medical authority= physician, physician assistants, nurse practitioners

EDNA MARTIN CHRISTIAN CENTER

Part 1. To be completed by a Parent, Guardian, or Authorized Representative		
Child's name:		Birthday: / /
Parent/Guardian/Authorized Representative name:		
Home Phone: ( )	Work Phone: ( )	
Address:		
City:	State:	Zip:

Part 2. For Children with a **DISABILITY**-Licensed Physician must complete	
Describe the patient's disability and the major life activities that are affected by the disability: _____ _____ _____	
Foods to be omitted: _____ _____ _____	Substitutions: _____ _____ _____

Part 3. For Children with special dietary needs that are **NOT A DISABILITY**-Recognized Medical Authority must complete	
Describe the medical or other special dietary need that restricts the child's diet: _____ _____ _____ _____	
Foods to be omitted: _____ _____ _____	Substitutions: _____ _____ _____
Please list foods and information regarding any needed texture changes (chopped, ground, pureed, etc): _____ _____ _____ _____	
Please provide any other information regarding the diet: _____ _____ _____	

_____
Physician/Medical Authority's signature

Date _____Telephone_____

_____
Printed Name and Title

City of Indianapolis, IN – CDBG Client Profile Form

1. **Client Name:** _____
2. **Date of Birth:** _____
3. **Address:** _____
4. **Phone Number:** _____
5. **Race** (Pick One):

___ White
___ Black/African American
___ Asian
___ American Indian/Alaskan Native
___ Native Hawaiian/Other Pacific Islander
___ Asian & White
___ Black/African American & White
___ American Indian/Alaskan Native & White
___ American Indian/Alaskan Native & Black
___ Other Multi-Racial

6. **Hispanic Ethnicity** ___ Yes ___ No
7. **Female Headed Household** ___ Yes ___ No
8. **Military Veteran Household** ___ Yes ___ No
9. **Disability** ___ Yes ___ No

10. **Income Guidelines:**
    a. Step 1 – Circle the number of persons in your household.
    b. Step 2 – Circle your household income range (under the number you already circled in Step. 1)

Number of Persons in Your Household

2016 AMI* EFFECTIVE 3/6/15	**1 Person**	**2 Persons**	**3 Persons**	**4 Persons**	**5 Persons**	**6 Persons**	**7 Persons**	**8 Persons**
0% - 30%	$0-12,400	$0-16,020	$0-20,160	$0-24,300	$0-28,440	$0-32,580	$0-36,500	$0-38,850
31% – 50%	$12,401-20,600	$16,021-23,550	$20,161-26,500	$24,301-29,400	$28,441-31,800	$32,581-34,150	$36,500	$38,850
51% – 80%	$20,601-32,950	$23,551-37,650	$26,501-42,350	$29,401-47,050	$31,801-50,850	$34,151-54,600	$36,501-58,350	$38,851-62,150
Over 80%	$32,951+	$37,651+	$42,351 +	$47,051 +	$50,851 +	$54,601+	$58,351 +	$62,315 +

I hereby certify that the information included on this form is correct to the best of my knowledge and that such information may be subject to verification by representatives of the City of Indianapolis and/or the United States Department of Housing and Urban Development for purposes of meeting the federal requirements of the Community Development Block Grant (CDBG) program.

Client Signature: _____ **Date:** _____/_____/_____

Policy Instruction 05-03

ENROLLMENT FORM

IDOE/CACFP
July 2012

Name of Institution_________________________________ Sponsor ID Number_________

Name of Facility___________________________________

Child's Name: ____ Birthdate: ______________________________

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (√) the meals your child normally receives while in care.	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__
If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc) Please check (√) here _________							

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant, and must be updated **annually**.

Printed name of parent/guardian: ____ Phone Number: _____________________

Signature of parent/guardian: ____ Date: ___________________________

EDNA MARTIN CHRISTIAN CENTER

CACFP Application for Free and Reduced Price Meals (Child Care)

Sponsor Name:	Phone Number: 317-637-3776
Center: Edna Martin Christian Center	FDC Provider:

Part 1. All Household Members

Names of all household (First, Middle Initial, Last)	Birth Dates of Children	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 4 to sign this form.	Check if NO income
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Part 2. Benefits: If any member of your household received [Food Stamps] or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to Part 3.**

Name:_____ Case number: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Insert center contact and phone number] Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often Check if NO income ☐

A. Name (List ONLY household members with income)	B. Gross income and how often it was received: 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: XXX - XX - _ _ _ _ ❑ I do not have a Social Security Number

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

Part 6: Other Benefits: The LAS allows us to tell Medicaid and Hoosier Healthwise that your children are eligible for free or reduced price meals. We may share your application information with Medicaid or Hoosier Healthwise unless you do not want us to. If you DO NOT want us to share this information, please sign here:

_____

Signature of Parent or Guardian

For information about Hoosier Healthwise health insurance call **1-800-889-9949**

Revised MAY 2017

CACFP Application for Free & Reduced Price Meals

CACFP Application for Free and Reduced Price Meals (Child Care)

A child enrolled in the day care facility may qualify for free or reduced price meals if the household income falls at or below the limits on this chart:

July 1, 2016 to June 30, 2017			
Household Size	Monthly Income	Household Size	Monthly Income
1	1,860	5	4,437
2	2,504	6	5,082
3	3,149	7	5,726
4	3,793	8	6,371
For each additional family member, add **$645**			

Part 7. Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native
❑ Not Hispanic or Latino	❑ White	❑ Native Hawaiian or Other Pacific Islander
	❑ Black or African American	

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.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Child Care Representative Use Only

Annual Income Conversion: Weekly X 52 – Every 2 Weeks X 26 – Twice a Month X 24 – Monthly X 12

SECTION A Mark one of the boxes below to show how you are going to determine eligibility.

❑ **Food Stamp or TANF Household**—The Food Stamp or TANF number meets the criteria for an acceptable case number. Complete Section B & C **OR**

❑ **Foster Child**—Compare the foster child's personal income to the guidelines. Complete Section B & C **OR**

❑ **Household Income**—Complete the information below and Complete Section B & C

Total Household Size: _____

Total Household Income

$_____/_____

Example: $100/week

Compare total household income to current USDA Income Eligibility Guidelines. When the household incomes are listed for different pay periods, you must convert all income to monthly or annual income. Use the conversion listed above.

SECTION B

Based on the information provided, this application will be:

❑ Approved Free ❑ Approved Tier I
❑ Approved Reduced ❑ Approved Tier II
❑ Paid

Use this space for income calculation.

SECTION C

_____
Signature of Sponsor Representative

_____
Date of Approval

THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED

Revised MAY 2017

CACFP Application for Free & Reduced Price Meals

PARENT AGREEMENT

I, _____ *(parent printed name)* agree to the following:

Please initial all.

_____ Pay the childcare fee of _____ per month/week/day/hour

_____ Make my payment on _____ (day of the week)

_____ To accept the late payment fee of _____ if payment is not received on time

_____ My child's typical arrival time will be _____

_____ My child's typical departure time will be _____

_____ To accept the late fee of $1.00 per minute per child after 6:00PM

_____ To keep my child's immunizations current and up to date as outlined by the STATE of INDIANA

_____ To keep my child's physical exam signed and completed by a physician

_____ To provide the first week's payment BEFORE my child starts

_____ To provide my CCDF approval letter/voucher.

_____ If a copay exists for my CCDF approval letter, the amount of $_____ must be paid on Fridays.

_____ That Before Care will open at 7AM but that my students must be present by 8:30AM.

_____ That After Care ends at 6PM and I will pick my child up by then or agree to have someone at home to receive my child after 6PM

_____ To accept all Safety Plans associated with all Edna Martin Christian Center Youth Programs as outlined in the Parent Handbook.

- *By signing below, I agree to the aforementioned statements as they apply to my child(ren) while attending the Edna Martin Christian Center programs and services*.

Printed Parent Name: _____

Parent Signature: _____Date: _____/_____/_____

Staff Signature: _____ Date: _____/_____/_____

"Like" the Edna Martin Christian Center Facebook page to stay current on updates and upcoming events!