Who We Are
The Early Childhood Education Arts Academy (ECEAA) is operated by the Christina Cultural Arts Center, Inc. funded through State and Federal sources, the Academy implements Head Start guidelines as its base requirements.

The Early Childhood Education Arts Academy embraces the philosophy that all children can learn and reach their highest potential when given the opportunity to be nurtured by involved parents, and to be taught by teachers who believe they can learn and excel. Parent engagement is key to child success. We provide systems for to participate and provide valuable input and feedback to the ECEAA community.

Our Star 5 program provides a culturally relevant, arts enriched learning experience that will prepare your child for kindergarten.

What We Do
Through the dedication of a Curriculum Coordinator, Lead Teacher and Assistant Teacher, the teaching team facilitates developmental achievement through exploration, and further educations the children through and in the Arts. Early Childhood Education Arts Specialists trained in the areas of music, movement, drama, and visual arts work with the children engaging and stimulating their natural creativeness and curiosity. The basic components of Head Start are also incorporated (i.e. health assessments/ Screenings, home visits, parent empowerment workshop, policy council, etc.) to maximize the opportunities for parent involvement.

Program Schedule
Our school year runs from September until June. The Arts day starts with breakfast at 8:30 a.m. and ends at 4:00 p.m. Extended care options are available, contact the ECEAA Director for more details.

Who is Eligible?
If you are the parent or Guardian of a child who will turn 3 ½ years old (42 months) on or before August 31, 2020 your child is eligible for the Arts Academy. Families with special needs are encouraged to apply.

Families meeting the attached income guidelines may be eligible for half day tuition free services. All income eligible families are prioritized according to the results of our enrollment point system. There are tuition slots available for parents who do not meet income guidelines. Our program does accept Purchase of Care.

How do I apply?
Applications for 2020 - 2021 may be picked up in the Registrar’s Office on the 1st floor during normal business hours or emailed to you. Completed applications (see required documentation on application) may be submitted to the main office, faxed, or mailed. Applications are not considered complete until all required documents are received. Once documents received acceptance in the program not obtained until parent interview complete by phone or in person.
INFO REQUIRED FOR ENROLLMENT PROCESS

A complete application consists of the following items:
- Child’s original birth certificate
- TANF verification (if applicable)
- 2 most recent pay stubs/letter from employer/agency verifying income
- Custody Consent form (if applicable)
- IEP (if applicable)
- Medical insurance card (Medicaid or other)
- Completed physical form for the current year with lead, hemoglobin, and HCT results
- Completed Dental Form or appointment card*
- Consent for treatment Form
- CACFP form
- Emergency Contact Sheet
- Authorization of Release Form
- Permission for Television and Video Viewing Form
- Photography Release Form
- Permission for Computer Usage Form
- Field Trip Permission Slip Form
- Permission for Program Screening Form

*Children must receive a dental screening-parents are required to complete this prior to the 1st day of school. We will accept confirmed dental appointments that are due after that date if they are scheduled within 30 days from the start date of the program.

INCOME ELIGIBILITY

The 2019 poverty guidelines are in effect as of February 1, 2019 (Federal Register vol. 84 pages 1167 – 1168).

<table>
<thead>
<tr>
<th># OF PERSONS IN FAMILY/HOUSEHOLD</th>
<th>POVERTY GUIDELINE</th>
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<tbody>
<tr>
<td>1</td>
<td>$12,490</td>
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<tr>
<td>2</td>
<td>$16,910</td>
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<tr>
<td>3</td>
<td>$21,330</td>
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<tr>
<td>4</td>
<td>$25,750</td>
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<tr>
<td>5</td>
<td>$30,170</td>
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<tr>
<td>6</td>
<td>$34,590</td>
</tr>
<tr>
<td>7</td>
<td>$39,010</td>
</tr>
<tr>
<td>8</td>
<td>$43,430</td>
</tr>
</tbody>
</table>

* For families/households with more than 8 persons, add $4,420 for each additional person.
ONLINE SCREENING – AGES & STAGES QUESTIONNAIRE (ASQ)

Once all documents are submitted and parent interview complete, Ages and Stages Questionnaires (ASQ) need to be completed. Call the Director or Family Service Coordinator to set up an appointment.

Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. You've been invited to participate in the Ages & Stages Questionnaires, Third Edition (ASQ-3) and Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE-2) to help you keep track of your child's general growth and social emotional development. You will be asked to answer questions about things your child can and cannot do. One questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving, and personal social skills. The second and final includes questions about your child's ability to calm down, take direction and follow rules, communicate, perform daily activities (e.g., eating, sleeping), act independently, demonstrate feelings, and interact with others.

MEET & GREET EVENTS AND HOME VISITS

Children and parents in the process or accepted into the ECEAA program are invited to a meet and greet event which will take place in either June or July of 2020.

Also, families accepted into the program will be contacted by ECEAA staff to complete home visits during the month of August. Within this meeting we will gather information about your child and family and set goals.

QUESTIONS
If you have any questions, please feel free to contact the Early Childhood Education Arts Academy Director or Family Service Coordinator at (302) 652-0101.

We are also available by email:
Daphne Evans – Family Service Coordinator devans@ccacde.org
Shysheika Edwards – Center Director sedwards@ccacde.org

Our fax number is: (302) 689-4719
Early Childhood Education Arts Academy
Christina Cultural Arts Center
705 North Market Street, Wilmington, Delaware 19801
(302) 652-0101 Phone (302) 689-4719 Fax
Academic Year 2020 - 2021

Application Date: ___________

Please mark all that applies: ECAP _________ POC_________ Tuition ___________
☐ Income Verified  ☐ Current  ☐ Tuition/Non-POC

ECEAA Staff Only: Acceptance Date______________  Enrollment Date__________

Please check to reassure that all applicable documents below are included with your application:

____ Birth Certificate  ____ IEP (if applicable)  ____ Emergency Contact Sheet
____ Custody Consent Form (if applicable)  ____ Proof of Income i.e. 2 pay stubs/TANF  ____ Authorization to Release
____ Current Medical Insurance Card  ____ Physical Form w/Lead/ Hemoglobin/HCT  ____ Television & Video Viewing
____ Dental Form or appt. card  ____ Consent to Treatment  ____ Photography Release
____ Consent to Treatment  ____ Field Trip Permission  ____ Program Screening form
____ Authorization to Release  ____ Computer Usage  ____ CACFP form

STUDENT INFORMATION

Date of Birth___________________

Name: ________________________________________________ (First) (Middle) (Last)

Address: __________________________________________________________

City: ____________________ State: ______________ Zip: ________________

Home Phone: ______________ Parent Email Address: _______________________________________

Has child attended child care in the last two years? _______Yes _______No
If yes please list the name(s): _________________________________
Briefly explain your reason for transition to our program? _______________________________

PARENT INFORMATION

Primary Caretaker(s) Date of Birth __________

Name: ____________________________________________ Relationship to Child: _______
(First) (Middle) (Last)

Place of employment/name of school: ______________________________________

Revised 2020
Work/Daytime Phone: ______________ Cell Phone: ______________ Evening Phone __________
Marital Status:  _____Single   _____ Married   _____ Separated   _____Divorced

**Is there a secondary Caretaker** (i.e. non-custodial parent, grandparent in home)?  ___Yes  ___No

Name: ________________________________ Relationship to Child: __________
(First)     (Middle)     (Last)

Place of employment/name of school: _____________________________________________

Work/Daytime Phone: ______________ Cell Phone: ______________ Evening Phone __________
Marital Status:  _____Single   _____ Married   _____ Separated   _____Divorced

**Non-Custodial parent information:**  Date of Birth __________
Name: ________________________________ E-mail: ________________________________
(First)     (Middle)     (Last)

Address: ______________________________________________________________________

City: ___________________________ State: __________ Zip: __________________________

**Primary Caregiver Questions**
Are you a teen parent?  ❑ Yes    ❑ No

Highest level of school completed:
❑ Grade 11 or less   ❑ High School   ❑ Associates   ❑ Bachelors   ❑ Masters

Work/Daytime Phone: ______________ Cell Phone: ______________ Evening Phone __________

How did you hear about our program?
❑ Flyer   ❑ Social Media   ❑ Website Search   ❑ Pamphlet   ❑ Referring Agency
❑ Employee: __________________________  ❑ Other: __________________________

**INCOME INFORMATION**
*A household consists of the child you are applying for, any adult caretakers for that child, and the siblings of that child who all reside in the same home

Total Number in Household*: __________ Income Amount: ______________
Number of children in Household*: __________ Number of Adults in household*: __________
Frequency of Income: _____Weekly  _____Bi-Weekly  _____Monthly  _____Yearly
Employed: ❑ Full-time  ❑ Part-time  ❑ School or Training  ❑ Retired or Disabled
❑ Unemployed
Source of Income:  _____ Wages  _____ Social Security  _____TANF
 _____ Child Support  _____Unemployment  _____ Other (specify)
Evidence of Income  _____ Payroll Stubs (2)  _____ Previous year’s taxes  _____W-2 Forms
 _____ S.S. Award Letter  _____ TANF Documents  _____Other (specify)
 _____ Foster Care Document  _____ Unemployment Compensation
Did you previously receive State Purchase of Care for child care expenses?  ____Yes  ____No
I/we certify that the above is true to the best of my /our knowledge. I understand that purposeful misrepresentation of information will result in the rejection of my application.

____________________________  ________________
(Parent/Guardian)  (Date)

____________________________  ________________
(Parent/Guardian)  (Date)

ECEAA does not discriminate based on race, color, national origin, sex, age, or handicap. Title 16, Chapter 9, Sections 901 to 909 requires that ECEAA staff report all sexual abuse, child abuse, and/or neglect to the Division of Child Protective Services. Rev. 01/09
# State of Delaware
Department of Services for Children, Youth and Their Families
Office of Child Care Licensing

## Name

---

## Birthdate

---

## Section A: Child Health Appraisal

**CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING:** Give additional comments below.

- [ ] Allergies (food, medicine, bee sting etc.)
- [ ] Frequent Colds
- [ ] Fainting
- [ ] Physical Handicap
- [ ] Hearing Difficulty
- [ ] Speech Difficulty
- [ ] Behavior Problem
- [ ] Constipation/Diarrhea
- [ ] Seizures
- [ ] Vision Difficulty
- [ ] Asthma

Comments:

**ADDITIONAL INFORMATION ABOUT YOUR CHILD** (include serious illness, accidents, operations, medications, etc. with dates):

---

**Parent/Guardian’s Signature**

**Date**

## Section B: To be Completed by Examining Physician/Pediatric Nurse Practitioner

<table>
<thead>
<tr>
<th>Code</th>
<th>X - Within Normal Limits</th>
<th>O - See Remarks Below</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Scalp, Skin</td>
<td>Heart</td>
</tr>
<tr>
<td></td>
<td>Vision</td>
<td>Ear, Nose</td>
</tr>
<tr>
<td></td>
<td>Lungs</td>
<td><strong>Hearing</strong></td>
</tr>
<tr>
<td></td>
<td>Throat</td>
<td>Abdomen</td>
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<tr>
<td></td>
<td>Blood Pressure</td>
<td>Eyes</td>
</tr>
<tr>
<td></td>
<td>Teeth</td>
<td>Extremities</td>
</tr>
<tr>
<td></td>
<td>Nervous System</td>
<td>Height</td>
</tr>
<tr>
<td></td>
<td>Weight</td>
<td></td>
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</tbody>
</table>

**REMARKS AND RECOMMENDATIONS:**

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**IS CHILD PROGRESSING NORMALLY FOR AGE GROUP?**

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**DTP/Hib 1**

<table>
<thead>
<tr>
<th>DTP/Hib 2</th>
<th>DTP/Hib 3</th>
<th>DTP/Hib 4</th>
<th>DTaP/Hib 4</th>
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**DTP/DTaP 1 / DT**

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<th>DTP/DTaP 2 / DT</th>
<th>DTP/DTaP 3 / DT</th>
<th>DTP/DTaP 4 / DT</th>
<th>DTP/DTaP 5 / DT</th>
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**Td 1**

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<th>Td 3</th>
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**OPV/IPV 1**

<table>
<thead>
<tr>
<th>OPV/IPV 2</th>
<th>OPV/IPV 3</th>
<th>OPV/IPV 4</th>
<th>TB Screening 12 mo</th>
</tr>
</thead>
<tbody>
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</table>

**MMR 1**

<table>
<thead>
<tr>
<th>MMR 2</th>
<th>Hep B 1</th>
<th>Hep B 2</th>
<th>Hep B/Hib 1</th>
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**Hib 1**

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<tr>
<th>Hib 2</th>
<th>Hib 3</th>
<th>Hib 4</th>
<th>Hep B/Hib 2</th>
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</table>

**Hep B/Hib 3**

<table>
<thead>
<tr>
<th>Varicella 1</th>
<th>Varicella 2</th>
<th>Influenza 1</th>
</tr>
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<tbody>
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</table>

**Influenza 2**

<table>
<thead>
<tr>
<th>Pneumococcal Polysaccharide 1</th>
<th>Pneumococcal Polysaccharide 2</th>
<th>Pneumococcal Conjugate 1</th>
<th>Pneumococcal Conjugate 2</th>
</tr>
</thead>
<tbody>
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</table>

**Pneumococcal Conjugate 3**

<table>
<thead>
<tr>
<th>Pneumococcal Conjugate 4</th>
<th>Hep A 1</th>
<th>Hep A 2</th>
<th>Lyme Vax 1</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Lyme Vax 2**

<table>
<thead>
<tr>
<th>Lyme Vax 3</th>
<th>Other:</th>
<th>Lead Screening 12 mo</th>
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</table>

**Examiner’s Signature**

**M.D.** or **P.N.P.**

**Date**

**Printed Name**

**Telephone**

---

**Doc. No.: 37-06-10-01-01**

Revised 2020
DENTAL VISIT FORM

NAME: ________________________________       DATE OF BIRTH: ____________

DATE OF VISIT: _______________________

SCHEDULED SERVICE (check all that apply):

☐ Oral Examination       ☐ filling
☐ Cleaning                ☐ extraction (temporary)
☐ Fluoride               ☐ extraction (permanent)
☐ x-ray                   ☐ root canal
☐ sealant                 ☐ Other: ____________

THIS CHILD WILL NEED MORE VISITS FOR THE FOLLOWING SERVICES (check all that apply):

☐ oral examination        ☐ filling
☐ cleaning                ☐ extraction (temporary)
☐ fluoride                ☐ extraction (permanent)
☐ x-ray                   ☐ root canal
☐ sealant                 ☐ Other: ____________

Comments:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Examiner’s Signature: ____________________________    Date: ____________
Printed Name: ________________________________    Phone: ______________
Address: ___________________________________________
Consent to Treatment

I ______________________________ am a parent/legal guardian of
________________________________________ who is a minor child. I hereby
authorize emergency medical treatment of any injury suffered by a child or any symptom that may,
in the judgment of the attending medical personnel, if untreated reasonably be expected to
threaten the health or life of my child. The consent provided, however, shall only be effective after
reasonable attempts have been made by the attending medical personnel to obtain my consent.

Signature: ___________________________ Relationship: ___________________________
Witness: ______________________________ Date: ______________________________
Home Address: ________________________________________________________________
Business Address: ______________________________________________________________
Home Phone: _________________________ Business Phone: _________________________
Alternate Phone: _____________________ Alternate Phone: _________________________

Medical Insurance Information:
Name of Company: ______________________________________________________________
Subscriber Name: ______________________________________________________________
Policy Number: _________________________________________________________________
Child’s Physician: ____________________________ Phone: __________________________
Child’s Dentist: ____________________________ Phone: __________________________
# Emergency Contact Sheet

**Child Name** 

---

**Parent/Guardian Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Daytime Phone</th>
<th>Daytime Phone</th>
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<th>Evening Phone</th>
<th>Evening Phone</th>
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<th>Alternate Phone</th>
<th>Alternate Phone</th>
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<th>Alternate Phone</th>
<th>Alternate Phone</th>
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</tbody>
</table>

If a parent/guardian cannot be contacted, please contact the following person(s) in case of emergency:

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Phone Number(s)</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Child Physician: __________________________ Phone: _________________

Child Dentist: ___________________________ Phone: __________________

List any health problems or allergies: ______________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Signature: ___________________________ Date: __________________________
Authorization of Release Form

Child Name ________________________________________________

This form authorizes ECEAA staff to release your child for pick-up to people listed below:

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Picture identification is necessary for authorized people to pick up your child. This list should be updated as necessary. Please inform the Lead Teacher and/or Aftercare Teacher of any changes. If someone other than the people listed above arrives to pick up your child, ECEAA staff will not release the child into their care without first contacting you. **Please note that children will not be released to anyone who is under the influence of alcohol or drugs, or who displays inappropriate behavior, regardless to whether they are listed on this form.**

*Please list phone number where you can be reached in the event of a pick-up question/concern.*

__________________________________________________________________________
Christina Cultural Arts Center  
Early Childhood Education Arts Academy  
705 N. Market Street  
Wilmington, DE 19801  

Permission for Television and Video Viewing  

This letter should serve as notice to the parents of the Early Childhood Education Arts Academy that the ECEAA staff must have permission to allow the children in the preschool program to view instructional/entertainment programming via television or video during the 2020-2021 program year. The television or video viewing will be limited to not more than one (1) hour per day and not more than two (2) days a week.

Please sign below indicating if you will allow/not allow your child to view programs via television or videos in their classroom.

☐ I give permission for my child to view videos or television in school.

☐ I do not give permission for my child to view video or television in school.

________________________________________________________________________
Child’s Name

________________________________________________________________________
Parent’s Name

________________________________________________________________________
Date
Christina Cultural Arts Center
Early Childhood Education Arts Academy
705 N. Market Street
Wilmington, DE 19801

Photography Release

For valuable consideration received, I __________________________ grant my full and irrevocable consent to Christina Cultural Arts Center (as well as its licensees, successors, and assigns) to use, reuse, reproduce, copyright, renew copyright and license for commercial and art purposes the photographs covered by this release form.

By my signature below, I understand that such grant allows the use of these photographs in any communications or promotional medium, domestic or foreign. Further, that these photographs may be presented alone or in conjunction with photographs of other persons, objects, text or translations, and with or without my name or accompanying quotation.

Photo Subject:

Child’s Name: ______________________________________

Signed: ___________________________________________  

Witness: ____________________________________________

Date: ______________________________________________

Consent by Parent or Guardian, In case of Minor

As a parent or legal guardian of person(s) named above, I consent to the terms of this release form.

Signed: ___________________________________________

Witness: __________________________________________

Date: _____________________________________________
Permission for Computer Usage

This letter should serve as notice to the parents of the Early Childhood Education Arts Academy that the ECEAA staff must have permission to allow the children in the preschool program to view instructional and/or supervised age appropriate entertainment programming via computers during the 2020-2021 program year.

Please sign below indicating if you will permit/not permit your child to use programs via computers in their school.

☐ I give permission for my child to view and access programs on the computer in school.

☐ I do not give permission for my child to view and access programs on the computer in school

________________________
Child’s Name

________________________
Parent’s Signature

________________________
Date
Field Trip Permission Slip

I, ___________________________ hereby give permission for ___________________________ (parent) (child) to attend all ECEAA sponsored field trips during the 2020–2021 school year. I understand that public/chartered transportation will be used for trips. I agree to not hold Christina Cultural Arts Center liable for any incident that may occur.

Parent Signature: ___________________________ Date: ___________________________
PERMISSION FOR PROGRAM SCREENING

CHILD’S NAME ___________________________ CENTER NAME - ECEAA

MEDICAID # ___________________________ DATE OF BIRTH ___________________________ SEX _____

The following program screenings are required or recommended by Head Start. Head Start will make arrangements for most screenings to be done. These Screenings are a part of the Head Start Program.

**DENTAL SCREENING** – The parent is required to escort their child to their initial screening to obtain the results to be given to Head Start. A screening shall include one or all of the following: an oral examination, cleaning, fluoride and/or x-ray. If the child qualifies, he/she will be seen at a Public Health Dental Clinic for the initial screening and follow-up treatment, at which time the FSC can transport the child to a scheduled appointment. All Dental Public Health forms need to be completed by the parent.

**DEVELOPMENTAL SCREENING** – An assessment of a child’s abilities in the areas of speech, language, large and small motor development and cognitive skills. These results will help us assess your child’s future success in school. This screening is done by the local school district personnel.

**HEARING SCREENING** – An audiometer, using headphones is used to test your child’s hearing at different levels

**HEIGHT/WEIGHT SCREENING** – Measurements will be taken in October and again in March by Early Childhood Education Arts Academy personnel. These measurements will let us know how well your child is growing.

**LEAD SCREENING** – Has to be done by your physician.

**ANEMIA SCREENING** – Has to be done by your physician.

**VISION SCREENING** – Visual acuity and Strabismus screenings are done to screen the child’s ability to see at a distance and to assess eye coordination.

ECEAA WILL NOTIFY YOU OF ANY ABNORMAL FINDING(S) and will assist you in obtaining further testing through other agencies if deemed necessary. All results will be given to you at the end of the program year on your child’s health summary statement.

*I have been informed about the above screenings and give permission for them to be performed on my child during the ECEAA Program Year of 2020 – 2021 from September to June. I also give permission for the results to be shared on a need to know basis between ECEAA, Public Health, WIC, private dentist or physician, appropriate local school and/or district.*

______________________________Signature (Parent/Guardian) Date _____________

______________________________Signature (Family Service Coordinator) Date _____________

Revised 2020
ADULT INCOME ELIGIBILITY FORM

PART 1 (Complete one application per household. Please use a pen, not a pencil.)

Definition of Household Member: “Anyone who is living with you and shares income and expenses, even if not related.”

List names of Enrolled Adult Participants.

<table>
<thead>
<tr>
<th>Adult’s First Name</th>
<th>MI</th>
<th>Adult’s Last Name</th>
<th>Date of Birth</th>
<th>Ethnicity Hispanic or Latino?</th>
<th>Race (check one or more):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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PART 2 - ENROLLMENT

Start Date: ____________________________
Arrival Time: ____________________________ AM/PM
Departure Time: ____________________________ AM/PM
Shift Work: ____________________________ Yes/No

Normal days of week Participant(s) is/are in care (circle all that apply): Mon Tues Wed Thurs Fri Sat Sun

Do any Household Members (including you) currently receive one or more of the following assistance programs: SNAP, SSI, or Medicaid? Check one: ☐ Yes / ☐ No

If you answered NO – Complete the Income section of Part 3.
If you answered YES – Write the name and case number for the person who receives benefits below, then go to Part 4.

NAME: ________________________________________
CASE NUMBER: ____________________________

All Adult Household Members (including yourself)

List all Household Members not listed in Part 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write “0.” If you enter “0” or leave any fields blank, you are certifying (promising) that there is not income to report.

<table>
<thead>
<tr>
<th>Names of ALL Household Members including spouse and dependent children of participant(s) (First/Last)</th>
<th>Earnings from Work (Before Deductions)</th>
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PART 3 – HOUSEHOLD INCOME

Do any Household Members (including you) currently receive one or more of the following assistance programs: SNAP, SSI, or Medicaid? Check one: ☐ Yes / ☐ No

If you answered NO – Complete the Income section of Part 3.
If you answered YES – Write the name and case number for the person who receives benefits below, then go to Part 4.

NAME: ________________________________________
CASE NUMBER: ____________________________

All Adult Household Members (including yourself)

List all Household Members not listed in Part 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write “0.” If you enter “0” or leave any fields blank, you are certifying (promising) that there is not income to report.

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PART 4 – CONTACT INFORMATION and ADULT SIGNATURE

An adult household member must sign and date this form before it can be approved.

“I certify (promise) that all information on this application is true and that all income is reported. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving the meals may lose the meal benefits, and I may be prosecuted under applicable State and Federal laws.”

Total Household Members (Children and Adults) Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household

Check if No SSN ☐

<table>
<thead>
<tr>
<th>Street Address (if available)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Daytime Phone and Email (optional)</th>
</tr>
</thead>
</table>
Printed Name of adult completing the form Signature of adult completing the form Today’s Date

SPONSOR USE ONLY:

Categorical Eligibility (If Yes, Check One): ☐ SNAP (Food Stamp) ☐ SSI ☐ Medicaid

Total Household Income: ____________________________ Family Size: ____________________________ (Include all Participants)

Yearly Income Conversion: Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12

ELIGIBILITY - Based on the information provided, this application will be:
☐ Approved FREE ☐ Approved REDUCED ☐ Denied – The meals will be claimed in the PAID category.

Determining Official Signature: ____________________________ Review/Effective Date: ____________________________

Revised 2020
Please complete the Child and Adult Care Food Program Income Eligibility Form using the instructions below. Sign the form and return it to the center/sponsor. Call the center/sponsor if you need help.

PART 1: PARTICIPANT(s) INFORMATION:
• Print the name(s) of all Participant(s) enrolled.
• RACIAL-ETHNIC IDENTITY: We are required to ask for information about the participant’s race and ethnicity. This information is important, and helps us to make sure we are fully serving the community. Responding to this section is optional, and does not affect the participant’s eligibility.

PART 2: ENROLLMENT
• Start date, arrival and departure times, normal days and normal meals must be completed at the time of enrollment and/or renewal.

PART 3: HOUSEHOLD INCOME
• List current SNAP, SSI, or Medicaid Case Number for the participant. DO NOT complete the Income section. Go to PART 4.

ALL Household Members (including yourself) complete this section. List all Household Members even if they do not receive income. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write “0”. If you enter “0” or leave any fields blank, you are certifying (promising) that there is not income to report.

• Write the names of everyone in your household.
• Write the amount of income received last month for each household member (the amount before taxes or before anything else is taken out), and where it came from, such as earnings, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount last month was more or less than usual, write that person’s usual income.

Note to Center/Reviewer: If you are uncertain of how the family receives income (monthly, weekly, bi-weekly, annually) consider the income reported as the income for the month. If this is not workable, contact the family for clarification.

### INCOME TO REPORT

<table>
<thead>
<tr>
<th>Earnings From Employment:</th>
<th>Pensions/Retirement/Social Security:</th>
<th>Other Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages/Salaries/Tips</td>
<td>Cash withdrawn from savings, Retirement Income</td>
<td>Disability Benefits</td>
</tr>
<tr>
<td>Strike Benefits</td>
<td>Veteran’s Payments</td>
<td>interest/Dividends</td>
</tr>
<tr>
<td>Unemployment Compensation</td>
<td>Social Security</td>
<td>Income from Estate/Trusts/Investments</td>
</tr>
<tr>
<td>Worker’s Compensation</td>
<td>Uniform allowances</td>
<td>Net Royalties/Annuities</td>
</tr>
<tr>
<td>Net income from self-owned business or farm</td>
<td>Regular contributions from persons not living in the household</td>
<td>Net Rental Income</td>
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<td></td>
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<td>Any Other Income</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Welfare/Child Support/Alimony:</th>
<th>Military Household:</th>
<th>Foster Child’s Income:</th>
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<tbody>
<tr>
<td>Public Assistance Payments</td>
<td>All cash income, including military housing/ uniform allowances</td>
<td>ONLY funds from welfare agency identified by category for personal use of child (clothing, school fees, etc.), funds from child’s family for personal use, and earnings from other sources (i.e., occasional or part-time employment) need to be included. <strong>DO NOT</strong> count funds from welfare agency for shelter, care, etc.</td>
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<tr>
<td>Welfare Payments</td>
<td>Does not include “in-kind” benefits NOT paid in cash (base housing, medical care, clothing, food, etc.)</td>
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<td>Alimony/Child Support</td>
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PART 4: CERTIFICATION - SIGNATURE AND SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART.

• All Income Eligibility Forms must have the signature of an adult household member.
• The adult household member who signs the form must include the last four digits of his/her Social Security Number IF the participant is eligible for “free or reduced” based on household income. Section 9 of the National School Lunch Act requires that unless the participant’s SNAP (food stamp), TANF case number is provided or the participant is a foster child or homeless, you must include the last four digits of the Social Security Number of the household member signing the statement, or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last 4 digits of the Social Security Number is not mandatory, but if a Social Security Number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP or TANF office to determine current certification for receipt of SNAP or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal action. If he/she does not have a Social Security Number, check the “I do not have a Social Security Number” box.
• If listed a SNAP, SSI, or Medicaid case number, the last four digits of a Social Security Number is not needed.

SPONSOR USE ONLY – Eligibility Determination: To be completed by ADULT Care Representatives ONLY. (1) Complete total household income and size section. Compare total income to Household Income Eligibility Guidelines. When household incomes are listed from different pay persons, you must convert all income to yearly income using the conversion table listed. Follow other instructions as indicated. (2) The review/effective date can be made retroactive back to the first day of participation in the CACFP as long as it occurs in the same month this form is received.

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, 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, i.e., Food Stamp), Temporary Assistance for Needy Families (TANF) Program 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 laws 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](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:
- mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW. Washington, D.C. 20250-9410
- fax: (202) 690-7442; or
- Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Revised 2020