STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER	STREET	CITY	STATE ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT

Email:

PAYMENT PROCEDURES AND DELINQUENCY

1) All tuition payments are due on the 1st of each month and no later than the 10th of each month.

2) Delinquent tuition will be charged a fee of $25.00 if not received by the 10th of each month. FAILURE TO KEEP TUITION CURRENT WILL TERMINATE THE STUDENT FROM THE PROGRAM. **A fee of $25.00 will be charged for returned checks.**

3) Any alternate payment arrangements must be submitted in writing and brought to the school board for review.

4) **Refunds:** THERE ARE NO MAKE UP DAYS FOR OR REFUNDS GIVEN FOR ABSENCES OR HOLIDAYS

5)**Vacations:** Each family receives a one week vacation credit per year. Request should be submitted in writing prior to vacation.

6) **Withdrawal:** TWO (2) WEEKS WRITTEN NOTICE IS REQUIRED. **If no notice is given you will be charged two (2) weeks after withdrawal.**

7) The following represents the basic services provided by Good Shepherd School and Child Care Center: Child care by qualified teachers, breakfast, lunch and afternoon snack to all full time students. Half day students breakfast and lunch is available at your choice. A complete description of policies and procedures is made available to parents of all enrolled children.

8) LICENSING: The Department of Social Services, our licensing agency, shall have the authority to interview children or staff and to inspect and audit child or facility records without prior consent.

A) The licensee shall make provisions for private interviews with any child/children or any staff member, and for the examination of all records relating to the operation of the facility.

B) The Department of Social Services shall have the authority to observe the physical condition of the child/children including conditions which could indicate abuse, neglect, or inappropriate placement, and to have a licensed medical professional physically examine the child/children.

9) The program at Good Shepherd Preschool and Child Care Center is offered to all children regardless of sex, race, color, national origin, or family dynamics.

10) While it is intended these terms remain unchanged during the full year, Good Shepherd Preschool and Child Care Center, with the approval of the Preschool Board, may amend these terms of fees upon thirty (30) days prior notice to parents of enrolled children.

I have read and understand the above and I acknowledge receipt of a copy of the Admission Agreement

Parent/Guardian Signature	Date	Starting Date
CHILDS NAME	Date of Birth	Program

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Good Shepherd Lutheran Preschool
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
( )

WORK PHONE
( )

GOOD SHEPHERD LUTHERAN CHURCH
PRESCHOOL AND DAY CARE CENTER
FIELD TRIP POLICY

1. Field trips are an important means of providing the children with a variety of learning experiences.
2. Alert supervision must be maintained at all times. The teacher in charge should be aware of the total group and the whereabouts of each child. No group of children shall be left without teacher supervision at any time. Planned projects and activities should be safe and child-centered.
3. The must be at least one (1) teacher present in accordance with our state license ratios. Other supplemental adults will be in the ratio of one (1) adult for every four (4) school age children.
4. Parents must give written permission and release for children to be taken on field trips. A form will be provided before each trip. Failure to complete and return this form will mean that child will not be able to participate in that field trip. The field trip should be scheduled no less than one (1) week in advance, and all details of the trip should be included at that time. Authorization of field trips will be obtained at the discretion of the Director.
5. If a parent transports children on a field trip, the Director must have, in advance of the trip, a copy of the parent's valid CA driver's license and a copy of a valid insurance policy covering the vehicle to be used. Each child must have a seat belt. Public transportation, such as Dial-A-Ride, may be used in lieu of private automobiles.
6. Parents are to be informed of any cost in advance. Payments should accompany the completed permission slip and must be received at least three (3) days in advance of the trip.

Cut on the line and return bottom to school

****

GOOD SHEPHERD LUTHERAN CHURCH
PRESCHOOL AND DAY CARE CENTER
AUTHORIZATION TO TREAT MINOR AND
PERMISSION TO PARTICIPATE

Name_____DOB_____AGE_____SEX_____
Parent/Guardian_____
Home Address_____City_____Home phone_____
Business Address_____City_____Work phone_____

If above named is not available in event of emergency, notify:
Name_____Phone_____Relationship_____
Physician_____Phone_____
Insurance_____Subscriber_____
Group Number_____ ID Number_____
Allergies_____
Current Medications_____

I give permission for my child/ward to participate in this activity sponsored by Good Shepherd Lutheran Church Preschool and Day Care Center. I understand that every effort will be made to contact me in case of an emergency. In the event I cannot be reached, I hereby grant authorization to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, for my child/ward.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

I GIVE PERMISSION FOR GSPS TO APPLY SUNSCREEN AS NEEDED. _____
INITIALS

DISCIPLINE POLICY

It is our desire at Good Shepherd to help children develop healthy emotions of love, confidence, and self-worth by teaching and building self-control and self-discipline. Children should begin to learn about respect and self-control at home and carry that through their school years...

Children learn through:

EXAMPLE-Children learn appropriate and inappropriate behavior by looking to us as examples. If we are anxious, angry, inconsistent, and domineering, our children will be distant, unconcerned, punitive and weak. If we are self-controlled, confident, loving and just, our children will be likewise.

MAKING MISTAKES-When a child makes a mistake then it is our responsibility to respond to the negative behavior. Here are steps to teaching self-discipline;

Step 1, speak to child directly, making eye contact. Be firm.

Step 2, redirect to another activity.

Step 3, loss of privilege.

Step 4, time out.

All discipline will be done in love, with self-control and patience.

Chronic discipline problems disrupt the flow of the class and interferes with children who are here to learn. When teachers have to direct much of their attention to the disruptions in the class. This does not make it fair to the others. Therefore in the event of chronic discipline problems these steps will be followed along with a note of "disruptive behavior" sent home for the parent to sign and return.

Step 1- The problem will be discussed between the child and the teacher.

Step 2-If this does not solve the problem, it will be discussed with the child, teacher, and Director. The parent will be informed of this discussion.

Step 3-Should the problem persist, the parent will be requested to come to school for a conference with the Director and teacher.

Step 4-If the problem is still unresolved and four notices were sent home within a one month period of time then the child may be removed from the school.

IT IS OF MAJOR IMPORTANCE THAT THE FAMILY AND SCHOOL WORK TOGETHER TO BEST MEET THE NEEDS OF THE CHILD IN TEACHING RESPONSIBILITY, RESPECT, AND SELF-CONTROL.

Parent Signature_____

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Palmdale Regional Office

   Licensing Office Address: 1605 E. Palmdale Blvd. Suite A Palmdale, CA 93550

   Licensing Office Telephone #: 661-789-6944

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Good Shepherd Lutheran Preschool
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Palmdale Regional Office

ADDRESS

1605 E. Palmdale Blvd. Suite A

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Palmdale	93550	661-789-6944

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
Good Shepherd Lutheran Preschool	329 S. Mill St. Tehachapi, CA 93561

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER

ANY FOOD DISLIKES?

ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A -- PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

Good Shepherd Lutheran Preschool . This Child Care Center/School provides a program which extends from 6 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 6:00 a.m./p.m., 5 days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
☐ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

Good Shepherd Photo Release

Please be advised that your child may be photographed or video-taped during classroom activities and school functions; for example, spirit week, Thanksgiving Feast and the Christmas Program. The preschool will reserve the rights to use these photos for our website, Facebook page and other advertisement purposes. These pictures and video clips help make our graduation video at the end of the year and will be a great way to share them with you over Facebook. Please sign and date and return ASAP.

☐ YES I give permission for my child to be in photo's and videos during classroom activities and school functions. I understand and give permission for these photos to be posted on the Preschool's Facebook page, Website and other advertisement purposes.

☐ NO. I decline and do not want my child in any photographs and/or videos.

Parent Signature: _____

Child's Name: _____

Date:_____

Thank you for being a Good Shepherd Family. God Bless.

MEAL BENEFIT FORM FOR CHILDREN
PROGRAM YEAR _____

Name of Child Care Center: Good Shepherd Lutheran Preschool and Child Care Center

Please read the instructions. If you need help completing this form call: 661-823-7740

Complete, sign, and return form to: Kristen Arnecke- Director

1. CHILD INFORMATION

List names of all children enrolled for care

Check the box if the child is a foster child (the legal responsibility of a welfare agency or court).

Last	First	M.I.	If all children are foster children, go to number (#) 4 and sign this form.
			☐
			☐
			☐
			☐

2. BENEFITS

If you are receiving CalFresh, CalWORKs, or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not** complete #3. Go to #4.

CalFresh Case #:
CalWorks Case #:
FDPIR Case #:

3. ALL HOUSEHOLD MEMBERS

Complete this section if you **did not** complete #2. List all household members including children enrolled for care. List all income. Go to #4.

☐ **Check here if this household receives no income.** Go to #4.

NAMES	**GROSS INCOME** and how often it was received (e.g. weekly, every two weeks, twice a month, monthly, or annually)*			
NAMES OF ALL HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)	**EARNINGS FROM WORK BEFORE DEDUCTIONS**	**CHILD SUPPORT, ALIMONY**	**PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY**	**EARNINGS FROM ANY OTHER INCOME**
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

*Applicants without income are requested to write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

Printed Name:	
Last Four Digits of SSN:	☐ Check here if no SSN
Signature of Adult:	Date:

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) 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 SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or 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 SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR 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 actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

If you choose to do so, please mark one or more of the following **racial** identities:		
☐ American Indian or Alaskan Native	☐ Asian	☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander		☐ White
Please mark one of the following **ethnic** identities:		
☐ Hispanic or Latino	☐ Not Hispanic or Latino	

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

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

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

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at 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

(3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

FOR AGENCY USE ONLY	
CATEGORICAL ELIGIBILITY CalFresh/CalWORKS/FDPIR household categorically eligible free? ☐ Yes ☐ No Foster child automatically eligible free? ☐ Yes ☐ No	
INCOME ELIGIBILITY Annual Conversion: Weekly times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthl 12	
Total Income:	Household Size:
Eligibility Classification ☐ Free ☐ Reduced-price ☐ Base	
Determining Official (Print Name):	
Determining Official Signature :	Certification Date:

HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the MBF to:

If you need help, call:

1. **CHILD INFORMATION:**
   a) Print your child's name. Print your child's name.
   b) Check box to right of name if a foster child.
   c) Include the name of the child care center.

2. **BENEFITS:** Complete this section and sign the form in #4.
   a) List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
   b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. **ALL OTHER HOUSEHOLDS:** Complete this section and sign the form in #4.
   Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. **If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.**
   a) Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
   b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
   c) Sign the form and include the last four digits of your SSN in #4. If you do not have a SSN, check the box "Check here if no SSN."

4. **LAST FOUR DIGITS OF SSN AND SIGNATURE:**
   a) The form must have a **signature** of an adult household member.
   b) The adult household member who signs the statement must include the last four digits of their **SSN**. If they do not have a SSN, check the box "Check here if no SSN". The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs, or FDPIR case number.

5. **RACIAL/ETHNIC IDENTITY:** You **are not required** to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work:
- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self- employment

Child Support/Alimony
- Public assistance payments
- Alimony/child support payments

Pensions/Retirement/Social Security
- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

Other Monthly Income
- Disability benefits
- Cash withdrawn from savings
- Interest dividends
- Income from estates/trusts/investments
- Regular contributions from persons not living in the household
- Net royalties/annuities/net rental income
- Military allowance for off-base housing
- Any other income

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE:

American Indian or Alaska Native–A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian–A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American–A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander–A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White–A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY:

Hispanic or Latino–A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term **Spanish origin** can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino