

**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

*****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
CHILD'S 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

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

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. Adult supervision must be maintained at all times. The teacher in charge must be aware of the total group and whereabouts of each child. No group of children shall be left without teacher supervision at any time. Planned projects and activities shall be safe and child-centered.
3. There must be at least one (1) teacher present in accordance with our state license ratios. Other supplemental adults will be in the ratio following state licensing ratios.
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 students will not be allowed to participate in field trips (including Chapel)
5. 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.

Good Shepherd Lutheran Church and
Preschool Authorization to Treat Minor and
Permission to Participate

Name: _____ DOB: _____ AGE: _____ SEX: _____

Parent/Gaurdian: _____ Home
Address: _____

Home Phone: _____ Work Phone: _____

If above named is not available in event of emergency, notify:

Name: _____ Phone: _____ Relationship: _____

Physician: _____ Phone _____

Insurance _____ Group/ID Number _____

Allergies: _____ Current Medications _____

I give permission for my child to participate in this activity sponsored by Good Shepherd Lutheran Church Preschool. I understand 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.

Parent Signature _____ Date _____

I give permission for GSPS to apply Sunscreen as needed: YES _____ NO _____

Parent Signature _____

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 appropriately. Here are steps to teaching self-discipline;

Step 1: Speak to child directly, at their level. Be firm while addressing inappropriate behavior.

Step 2: Redirect to another activity.

Step 3: Loss of privilege

Step 4: "Break time" (removal from group activity/ 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 attentions to the disruptions in the class, it takes away from the other children and is not fair. 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 for a conference with the teacher and Director.

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: 39115 TRADE CENTER DRIVE SUITE 201 PALMDALE, CA 93550

Licensing Office Telephone #: 661-202-3318

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

39115 TRADE CENTER DRIVE SUITE 201

CITY

PALMDALE

ZIP CODE

93551

AREA CODE/TELEPHONE NUMBER

661-202-3318

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)

GOOD SHEPHERD LUTHERAN PRESCHOOL

(PRINT THE ADDRESS OF THE FACILITY)

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)

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
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> 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?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

WORD USED FOR "BOWEL MOVEMENT"?* WORD USED FOR URINATION?*

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

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

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 : 0
(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: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

Physician Physician's Assistant Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

- * Have a family member or contacts with a history of confirmed or suspected TB.
- * Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- * Live in out-of-home placements.
- * Have, or are suspected to have, HIV infection.
- * Live with an adult with HIV seropositivity.
- * Live with an adult who has been incarcerated in the last five years.
- * Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- * Have abnormalities on chest X-ray suggestive of TB.
- * Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

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 2021-2022**

Name of Child Care Center: _____

Please read the instructions. If you need help completing this form, call: _____

Complete, sign, and return form to: _____

1. CHILD INFORMATION

List names of all children enrolled for care.

Last Name	First Name	Middle Initial	Foster Child?*

*If all children listed are foster children, go to Section 4.

2. BENEFITS

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

Program	Case Number
CalFresh	
CalWORKs	
FDPIR	

3. ALL OTHER HOUSEHOLDS

Complete this section if you did not complete Section 2. List all household members including children enrolled for care. List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

Check here if this household receives no income. _____ Go to Section 4.

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.

Names of all household members, including child(ren) listed above	Earnings from work before deductions	Child support, alimony	Payments from pensions, retirement, Social Security	Earnings from any other income
Example: Janet Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$0

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: _____ **No SSN:** _____

Signature of Parent or Guardian: _____

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 _____

FOR AGENCY USE ONLY

CATEGORICAL ELIGIBILITY

CalFresh/CalWORKS/FDPIR household categorically eligible? Yes _____ No _____
Foster child automatically eligible free? Yes _____ No _____

INCOME ELIGIBILITY

Annual Conversion (required if household reports various pay frequencies in Section 3):
weekly times (x) 52, every 2 weeks x 26, twice a month x 24, monthly x 12
Total Household Income and Frequency: \$ _____ per _____
Household Size _____

ELIGIBILITY CLASSIFICATION

Eligibility Classification: Free _____ Reduced-price _____ Base _____
Determining Official Name: _____
Determining Official Signature: _____ Date: _____

HOW TO COMPLETE THE MEAL BENEFIT FORM

1. CHILD INFORMATION:

- a. Print your child's name.
- b. Indicate **yes** to the right of child's name if a foster child.

2. BENEFITS: Complete this section, then skip to Section 4 and sign the form.

- a. List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
- b. Sign the form in Section 4. An adult household member must sign. You do not have to list an SSN.

3. ALL OTHER HOUSEHOLDS: Complete this section only if you do not have a case number.

- a. Complete this section and sign the form in Section 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.
- b. 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.
- c. 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.
- d. Sign the form and include the last four digits of your SSN in Section 4. If you do not have an SSN, place a checkmark next to **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 his or her SSN. If they do not have an SSN, they will place a checkmark next to the **No SSN** line.

- c. The last four digits of the adult household member's SSN is not needed if a CalFresh, CalWORKs, or FDPIR case number is provided.

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, or tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self-employment

Child Support or Alimony

- Public assistance payments
- Alimony or child support payments

Pensions, Retirement, or 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, or investments
- Regular contributions from persons not living in the household
- Net royalties, annuities, or 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 two ethnic categories:

RACE

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

ETHNICITY

Hispanic or Latino
Not Hispanic or Latino

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

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