



**ORANGE COUNTY  
SCHOOL AGE CHILD CARE**

**REGISTRATION PACKET**

**January 2017**

**Orange County  
School Age Child Care Program  
Application Checklist**



***You must complete or include all documentation below***

For your convenience, we have included this checklist to be sure your application is complete PRIOR to your child starting the OCSACC Program. Please check each item as it is completed and include this form along with needed documents with the application when registering.

\_\_\_ Expected start date: \_\_\_\_\_

\_\_\_ Application & Medical Treatment Authorization (first two pages)

\_\_\_ Public Recognition, Field Trip Permission, & Code of Conduct

\_\_\_ Responsible Party Form

\_\_\_ Financial Responsibility

\_\_\_ Information records release

\_\_\_ Medication Authorization forms (if needed)

\_\_\_ Custodial Papers (if needed)

\*\*OCSACC cannot deny a parent the right to pick up their child unless a custodial agreement is on file.

\_\_\_ Immunization form

\*\*Do not need to include these if your child is attending the school in which the OCSACC is housed for which you are registering

\_\_\_ Physical examination form

\*\*Do not need to include these if your child is attending the school in which the OCSACC is housed for which you are registering

\_\_\_ Proof of Identity (ORIGINAL birth certificate)

\*\*Staff will not make a copy, however, will document pertinent information below

***Staff Use Only:***

Proof of identity - *must be provided before admission*

Document type \_\_\_\_\_ Certificate # \_\_\_\_\_

State \_\_\_\_\_ Date of Birth \_\_\_\_\_ Staff Initials \_\_\_\_\_



## Orange County School Age Child Care Program Registration Package

**Student Information:**

Name:		Nickname:		Sex:	
Address:					
Phone:			Social Security Number:		
Date of Birth:			School Attending:		Grade:
Summer Status:      Full time      Part time			Hours expected to attend:		
School Year Status:    Full time-AM    Full time-PM    Full time-AM/PM    Drop in-AM    Drop-in-PM					
Registration Status:    Summer only (\$50)    School Year Only (\$100)    Full year (\$125)    **all registration fees are "per child"					

**Parent or Legal Guardian Information:**

Unless a custodial agreement is provided, or a parent is deceased, information on ***BOTH parents is required by licensing standards.***

	Mother	Father
Name		
Social Security Number		
Relationship		
Home Address (if different)		
Home Phone (if different)		
Cell or Pager #		
Employer		
Work Address		
Work Phone		
Work Schedule		
Email address		

**Previous Child Day Care Programs & Schools Attended:**

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**Authorized to Pick Up Student:**

**NOT Authorized to Pick Up Student:**

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**\*Note - We cannot refuse a parent who wishes to pick up children UNLESS we have a copy of a Custodial Agreement in your child's file.**

PLEASE PRINT ALL INFORMATION

Child's Name:	Date of Birth:
Address:	

**Emergency Contacts:** to be contacted in an emergency situation when parents or guardians cannot be reached.

At least one person must be LOCAL - readily accessible for your child.

	Contact #1	Contact #2
Name		
Home Telephone #		
Work Telephone #		
Cell Phone or Pager #		
Street Address (NO PO BOXES)		
E-mail Address		

**Child's Health Information:**

Allergies (please list any symptoms that may be exhibited):
Physical Conditions & Pertinent Developmental Conditions:
Restrictions to Activity:
Medications (currently taking):
<b>Action to take in an emergency:</b>

Family Physician:	Phone #:
Address:	

OCSACC will be provided with a copy of current immunization records prior to the first day of attendance. Updated information on immunizations will be provided upon request by OCSACC. Parents will also provide a copy of physical examinations within one month of first day of attendance (or give permission to be received from Orange County Schools). In the event children are exposed to a communicable disease at our center, (based on the Dept. of Health's current chart), parents will be notified within 24 hours or the next business day, unless forbidden by law. In the event of a life threatening disease, parents will be notified immediately. Parents are also required to notify the Child Care site within 24 hours or the next business day, if the child or any member of the immediate family within the household develops a communicable disease. (Note - life threatening diseases must be reported immediately.)

In the event the child whose name appears above becomes sick or injured the parents, guardians, or the emergency contact persons, once notified, will immediately arrange for the child to be picked up from the program. **However, if the child requires emergency medical treatment, the staff of the Orange County School Age Child Care is hereby authorized to obtain treatment of the child by qualified personnel and if circumstances warrant, to allow the transportation of the child to a hospital.** It is understood that this authorization covers only those situations that are true emergencies and only when parents, guardians, or emergency contacts cannot be reached. ***The person whose signature appears below agrees and understands that he/she will be fully responsible for any medical costs incurred by child, or on behalf of child, and that the Orange County School Age Child Care Program does not provide any sort of medical insurance or medical bill expense reimbursement or payment, for or on behalf of any child.*** It is also understood that a photocopy of this authorization will be as valid as the original.

Signature:	Date:
Relation to Child:	

# Orange County School Age Child Care Program



## Public Recognition Authorization

I understand that from time to time the Orange County School Age Child Care Program may wish to recognize students for special accomplishments by having their names or pictures or both appear in print or film media. I hereby give permission for the name and picture of my child, \_\_\_\_\_, to be used for such a purpose.

## Field Trip Permission Form

I understand that from time to time the Orange County School Age Child Care Program may wish to take field trips. I acknowledge that I will be informed of said field trips and will be given the opportunity to withdraw my child from this field trip. This withdrawal from a specific field trip will be submitted in writing. I hereby give permission for my child, \_\_\_\_\_ to participate in field trips.

## Code of Conduct

I understand that my child will be expected to:

- Respect the rights and properties of others.
- Cooperate by observing the rules and refraining from foul language.
- Disrespectful backtalk or physical contact with another child or staff member.
- Take advantage of all enriching opportunities presented.

I have read and discussed the Code of Conduct with my child and we understand that breaking the Code of Conduct could result in the child being terminated from the program.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Orange County School Age Child Care Program



## Responsible Party Form

Child's Name: \_\_\_\_\_

Site Attending: \_\_\_\_\_

I understand that upon acceptance into the Orange County School Age Child Care Program, the following persons or entity is responsible for all child care fees incurred. I also understand that in the event financial assistance from below listed entity is denied, that I am still ultimately responsible for all charges as they accrue.

Responsible Party's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date: \_\_\_\_\_

*I am receiving financial assistance from:*

Name \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

**Orange County  
School Age Child Care Program**



**Financial Responsibility Clause**

I understand that upon acceptance into the Orange County School Age Child Care Program, I am responsible for the payment of the program registration fee, attendance fees, insurance fee (if applicable), and any penalty fees as they become due.

I also understand that should I be receiving financial assistance from another agency, I am still ultimately responsible for all charges as they accrue.

I understand that my child may not be allowed to attend the Child Care Program in the event payments are not received on time. I also understand that withdrawing my child from the program does not eliminate my need to continue to make payments for monies owed.

I also understand that my account may be turned over to the Orange County Treasurer's Office for collection in the event it becomes past due. In addition, I understand I will also be responsible for any and all additional fees charged by the Orange County Treasurer's Office in the event my account is turned over for collection.

I am enclosing the non-refundable registration fee.

\*\*Mother/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*Father/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*Both signatures required for paperwork to be complete unless a custody agreement is on file or there are extenuating circumstance. Please speak with your Site Director if you have any questions.

\*\*The Orange County School Age Child Care Program does not discriminate on the basis of race, gender, color, religion, marital status, disability, or national & ethnic origin. If payment fees present a financial burden on your family, please contact the Department of Social Services. Financial assistance may be available.

**Orange County Department of Social Services**

146 Madison Road, Suite 201

Orange, VA 22960

(540) 672-1155

# Orange County School Age Child Care Program



## Information & Records Release Form

Child's Name: \_\_\_\_\_

School where records are located: \_\_\_\_\_

I hereby authorize for the above school to release a copy of my child's Social Security Number, Birth Certificate verification form, physical examination and immunization record to the Orange County School Age Child Care Program.

In addition, I hereby give my permission for the Child Care staff to discuss my child with the staff of the school they are attending. This will enable the Child Care staff to better assist my child with homework, behavior management, and the day to day operation of the site.

I understand that all information and records released to the Child Care Program will remain confidential. As mandated by licensing standards, all participant files will be locked and are available to the staff only with the approval of the Program Director.

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

\*\*\*\*\*

### ***Office Use Only:***

We will need the following on this child:

	Date Requested	Date Received
Social Security Number	_____	_____
Physical Form	_____	_____
Immunization Form	_____	_____
Birth Certificate Verification Form	_____	_____

# Orange County School Age Child Care Program



## Medication Administration

The OCSACC Programs provide the parents the opportunity to be sure their children receive medication both as needed (Ex: Tylenol for a fever) and on a regular basis (Ex: Ritalin for ADD/ADHD). Please be advised NOT ALL OCSACC staff is trained for this service. In the event, a staff member will not be on-site while your child is in attendance, you will be notified as quickly as possible in case alternate arrangements need to be made. Staff must attend and eight (8) hour Medication Administration class as required by the Va. Dept. of Social Services before they can administer ANY medication (excluding sunscreen and antibiotic ointment). Please review our medication administration policy located on pages 15 and 16 of the OCSACC Parent Handbook prior to filling out the following medication permission forms. They provide details on which part of each form needs to be completed.

### Please remember:

- ❖ In compliance with licensing regulations, medications will be strictly monitored.
- ❖ Medication will only be given to children when parents have supplied the appropriate release forms, with **ALL INFORMATION** completely filled out.
- ❖ Medication can only be given for ten (10) working days without written consent from a doctor and must be given to the Site Director or their designee immediately upon arrival at the site.
- ❖ Please do not send any medication with your child without written authorization.
- ❖ **All medication must be in the original container and labeled with the child's name, dosage amount and the time/times to be administered.**
- ❖ The labels must match the instructions written on the Medication Administration Form.
- ❖ **ALL** medications will be stored by OCSACC staff.

Some OCSACC staff is also trained in Emergency Medication Administration, including, but not limited to, inhalers, epi-pens and nebulizers. Emergency medication must be authorized by a doctor - using the long term medication form. Children cannot be in possession of their emergency medications - the Site Director or Lead Teacher in charge of their group will maintain possession of the medication while the child is on site.

The next two pages include our standard Non-Prescription Over-the-Counter (OTC) skin product authorization form as well our regular Medication Authorization Form to be used for all other types of medication administration. (Ex: Tylenol, Ritalin, Epi-pens, etc.) Again, please review our medication administration policy located in the parent handbook or speak with your Site Director for more information.



# Medication Authorization Form

## Orange County School Age Child Care Programs

For Prescription and Non-prescription Medications

### Instructions:

- One medication per authorization form.
- **Section A** must be completed by the parent/guardian for ALL medication authorizations
- **Section A and Section B** must be completed for an **long-term medication** authorizations (those lasting longer than 10 working days)

**PLEASE PRINT**

### **SECTION A: To be completed by parent/guardian**

Medication authorization for: \_\_\_\_\_  
(Child's Name)

The **Orange County School Age Child Care (OCSACC) staff** has my permission to administer the following medication:

Medication Name: \_\_\_\_\_

Dosage and Time(s) to be administered: \_\_\_\_\_

Special Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until \_\_\_\_\_.  
(Start Date) (End Date)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE PRINT**

### **SECTION B: To be completed by child's physician**

I, \_\_\_\_\_ certify that it is medically necessary for the medication  
(Name of Physician)

listed below to be administered to: \_\_\_\_\_ for a duration that exceeds 10 work days.  
(Child's Name)

Medication Name: \_\_\_\_\_

Dosage and Time(s) to be administered: \_\_\_\_\_

Special Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until \_\_\_\_\_.  
(Start Date) (End Date)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_



# Authorization Form for Non-Prescription Over-the-Counter Skin Products Orange County School Age Child Care Programs

## INSTRUCTIONS:

This form must be completed by the parent/guardian to authorize use of:

- Sunscreen
- Insect Repellent
- Bee Sting Swabs
- Antibiotic Ointment

❖ The Orange County School Age Child Care Staff (OCSACC) has my permission to apply the non-prescription over-the-counter (OTC) skin product listed below to my child: \_\_\_\_\_  
(Child's Name)

❖ Please check which item you are giving permission for use:

\_\_\_ Antibiotic Ointment for first aid purposes (will be provided by OCSACC Program)

\_\_\_ Sunscreen → \_\_\_ Will provide my own \_\_\_ Will use OCSACC product

\_\_\_ Insect Repellent (must be provided by the parent/guardian) Name of product: \_\_\_\_\_

\_\_\_ Bee sting swabs (will be provided by OCSACC Program)

\_\_\_ Other → name of Product: \_\_\_\_\_

❖ Please list any known adverse reactions (if any) to the above products – if none, write “N/A”:

\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

### ❖ All OTC products must:

- Be in the original container and, if provided by the parent, labeled with the child's name
- Be used in accordance with manufacturer's recommendation and instructions for application
- Not be used beyond the expiration date of the product

### ❖ Sunscreen:

- Must have a minimum sunburn protection factor (SPF) 15
- Shall be inaccessible to children under 5 yrs.
- Children nine (9) yrs. and older may self administer sunscreen if supervised

### ❖ Insect Repellent / Other topical Ointments

- Shall be kept inaccessible to children
- Record of use shall be kept that includes child's name, date, frequency of application, and any adverse reactions

This authorization is effective from: \_\_\_\_\_ until \_\_\_\_\_  
(Start Date) (End Date)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CHILD AND ADULT CARE FOOD PROGRAM**  
**MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) / FISCAL YEAR 2016**  
**PARENT LETTER**

Dear Parent or Guardian:

This child care center participates in the United States Department of Agriculture Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information provided on the attached CACFP Meal Benefit Income Eligibility Form (IEF). Part of the USDA requirement is to complete the IEF. If household income is equal to or less than the income listed in the chart below for household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. Please return the completed IEF back to our center as soon as possible.

If a member of the family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) benefits or cares for a foster child(ren) that is the legal responsibility of Virginia Department of Social Services or the court, these children are eligible for meal benefits regardless of household income.

If the household income(s) is over the income guidelines listed below, please write each child's name that is enrolled in the child care program in Section 1 and complete section 6. Please notify us if someone in the household becomes unemployed and the loss of income causes the household income to be within the income eligibility standards.

The information provided on the IEF will be used to determine the child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

***Family Access to Medical Insurance Security Plan (FAMIS)***

**FAMIS** is Virginia's health insurance program for children. It provides access to quality health services for children who do not have health insurance. **FAMIS Plus** is Virginia's name for children's Medicaid. **FAMIS Plus** also provides great benefits and covers children in families with low or no income, even if the children are covered by health insurance.

By signing the section on the application for **FAMIS** or **FAMIS Plus**, the family is stating they do not want information shared with the local Department of Social Services. If IEF information is disclosed, it may be used to identify the child(ren) for the health insurance program. More information on **FAMIS** is available at 1-866-873-2647 – Interpreters are available. Log onto [www.famis.org](http://www.famis.org) to apply online.

A household with income less than or equal to the income chart for reduced-priced meals below is eligible for free or reduced-priced meals:

Household Size	Yearly
1	\$21,775
2	\$29,471
3	\$37,167
4	\$44,863
5	\$52,559
6	\$60,255
7	\$67,951
8	\$75,647
Each additional person:	\$7,696

Please contact our center with any questions or for additional help.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

**PARENT INSTRUCTIONS**  
**CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM**

Attachment M3b - IEF  
Parent Instructions

Follow These Instructions and Return the Completed form to your Center. Once approved for meal benefits, a child's Income Eligibility Form (IEF) is effective for 12 months.

**FOSTER CHILD(REN)**

A foster child remains the legal responsibility of the State through a foster care agency or the court.

- 1) If all children in your household (who attend this center) are foster children that are the legal responsibility of a foster care agency or court, provide the following:
  - Part 1—List the name(s) and age(s) of your foster child(ren) attending this center.
  - Part 2—Check the box(es) indicating a foster child(ren).
  - Part 3—5 Skip
  - Part 6—Provide a signature of an adult household member and date the application.
  - Part 7-8 (OPTIONAL)
  
- 2) If you have some foster children that are the legal responsibility of a foster care agency or court along with other children attending this center, please provide the following:
  - Part 1—List ALL household members, including the foster child(ren), and the age(s) of the child(ren) attending the center.
  - Part 2—Check the box(es) identifying the foster child(ren).
  - Part 3—Record a valid SNAP/TANF case number if applicable
  - Part 4—Skip
  - Complete Parts 5 and 6 if applicable. See the instructions for **INCOME-HOUSEHOLDS REPORTING** section.
  - Part 7-8 (OPTIONAL)

**SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING**

If any member (child or adult) of your household receives SNAP or TANF benefits, provide the following:

- Part 1—List ALL people in your household (including grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the center.
- Part 2—Skip
- Part 3—Record a valid SNAP or TANF case number for any member (child or adult) of this household. You will find your SNAP or TANF case number on your letter of eligibility for benefits. All SNAP and/or TANF case numbers are 7 digits.
- Part 4—5 Skip
- Part 6— Provide a signature of an adult household member and date the application.
- Part 7-8 (OPTIONAL)

**HOMELESS, MIGRANT, OR RUNAWAY**

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant or runaway, follow these instructions.

- Part 1—List ALL household members, and the age(s) of the child(ren) attending the center.
- Part 2—3 Skip
- Part 4—If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your local school.
- Part 5—Complete only if a child in your household isn't eligible under Part 4. See instructions for **INCOME-HOUSEHOLDS REPORTING** section below and complete Part 5 and 6.
- Part 6—Provide a signature of an adult household member and date the application.
- Part 7-8 (OPTIONAL)

**INCOME - HOUSEHOLDS REPORTING**

If no one in your household receives SNAP or TANF benefits, please report all household income. The Income Eligibility Form must include the following information:

- Part 1—List the names of ALL household members and the age(s) of the child(ren) attending the child care center. For any person, including children, with no income, you must check the "No Income" box.
- Part 2—4 Skip
- Part 5—List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
  - o For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - o If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
- Part 6—Provide a signature of an adult household member and date the application. Also, provide the last four digits of the social security number for the adult signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a social security number, mark the box, "I do not have a social security number."
- Part 7-8 (OPTIONAL)

**VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES**

<b>1 All Household Members</b>				<b>2</b>		<b>3</b>							
NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] <small>First, Middle Initial, Last</small>				FOSTER CHILD <small>Skip to Part 6 if all are foster children.</small>		SNAP, TANF or FDIPIR CASE # <small>Skip to Part 6 if you list a SNAP, TANF or FDIPIR case number. <b>MUST BE SEVEN (7) DIGITS</b></small>							
				Check if <b>NO</b> income	Ages of children at center								
1.				<input type="checkbox"/>		<input type="checkbox"/>							
2.				<input type="checkbox"/>		<input type="checkbox"/>							
3.				<input type="checkbox"/>		<input type="checkbox"/>							
4.				<input type="checkbox"/>		<input type="checkbox"/>							
5.				<input type="checkbox"/>		<input type="checkbox"/>							
6.				<input type="checkbox"/>		<input type="checkbox"/>							

**4 Homeless, Migrant, or Runaway**

Homeless     Migrant     Runaway    If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison, Migrant Coordinator.

**5 Total Household Gross Income (before deductions). You must tell us how much and how often.**

NAMES <small>(LIST ALL HOUSEHOLD MEMBERS WITH INCOME)</small>	GROSS INCOME AND HOW OFTEN IT IS RECEIVED <small>(Example: \$100/month, \$100/twice a month, \$100/every other week, \$100/week)</small>							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	\$		\$		\$		\$	
ii.	\$		\$		\$		\$	
iii.	\$		\$		\$		\$	
iv.	\$		\$		\$		\$	
v.	\$		\$		\$		\$	

**6 Signature and Social Security Number (Adult must sign)**

An adult household member must sign the application. **If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the I do not have a social security number box.**

X X X - X X - \_\_\_\_\_  
Social Security Number

I do not have a social security number.

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

\_\_\_\_\_

Date Printed Name of Adult Household Member Signature of Adult Household Member

**7 Contact Information (Optional)**

\_\_\_\_\_

Work Telephone Number (Include Area Code) Home Telephone Number (Include Area Code) Home Address (Number, Street, City, State, Zip Code)

**8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)**

May we share your information on this application with the FAMIS, the complete health insurance program for every child in Virginia? **If yes, do not sign below.**

No, I do not want my information from this application shared with the FAMIS.    Date: \_\_\_\_\_    Sign here: \_\_\_\_\_

**PRIVACY ACT STATEMENT:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of your social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDIPIR identifier for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

**NON-DISCRIMINATION STATEMENT:** The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov). Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

**CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW**

SECTION A	Annual Income Conversion:    Weekly X 52    Every 2 Weeks X 26    Twice a Month X 24    Once a Month X 12	Convert income only if different frequencies of pay are reported.
TOTAL INCOME \$ _____ Per: <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month <input type="checkbox"/> Year		NUMBER IN HOUSEHOLD: _____
<input type="checkbox"/> FREE based on: <input type="checkbox"/> foster child <input type="checkbox"/> migrant <input type="checkbox"/> SNAP or TANF <input type="checkbox"/> homeless <input type="checkbox"/> runaway <input type="checkbox"/> household income		<input type="checkbox"/> REDUCED based on: <input type="checkbox"/> household income
		<input type="checkbox"/> DENIED reason: <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> non-qualifying SNAP/TANF

**SECTION B**    Signature of Determining Official: \_\_\_\_\_    Date: \_\_\_\_\_

## Annual Enrollment Form

### Virginia Child and Adult Care Food Program

#### Center Information

*Please check which center your child will be attending.  
\*If your child may attend more than one site, please check both sites in which your child will attend.*

Gordon Barbour Child Care - 500 West Baker Street Gordonsville, VA 22942

Orange Elementary Child Care - 230 Montevista Avenue Orange, VA 22960

Locust Grove Child Care - 21230 Constitution Highway, Locust Grove, VA 22508

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for children. Federal CACFP regulations require all parents or guardians to complete and review an annual Enrollment Form when enrolling their child(ren) and 12 months thereafter. This information will help ensure all children receive appropriate meals during their care. **The parent or guardian must complete and ensure accuracy of Sections 1 through 5.**

#### This form is required for:

Child Care Centers, Head Start, and Even Start

#### This form is NOT required for:

At-Risk After-School, or Emergency Shelters, or Licensed Outside School Hours Programs

1	FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2	DAYS OF WEEK IN ATTENDANCE	3			4	MEALS RECEIVED
				TIMES CHILD NORMALLY ATTENDS DURING WEEK				
	<i>Child's First Name</i>		<input checked="" type="checkbox"/> Monday <input checked="" type="checkbox"/> Tuesday <input checked="" type="checkbox"/> Wednesday <input checked="" type="checkbox"/> Thursday <input checked="" type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	TIME IN	TIME OUT	SPORADIC SCHEDULE	<input type="checkbox"/> Breakfast <input checked="" type="checkbox"/> AM Snack <input checked="" type="checkbox"/> Lunch <input checked="" type="checkbox"/> PM Snack <input type="checkbox"/> Supper	
	<i>Child's Last Name</i>							
	<i>Date of Birth</i>			Notes				

#### 5 Signature and Date

*I certify the information above is correct.*

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent's Telephone Number*

**NON-DISCRIMINATION STATEMENT:** The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov). Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

## CACFP Meal Benefit Income Eligibility Form (Child Care Centers) Frequently Asked Questions

The Child and Adult Care Food Program (CACFP) provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form.

**1. Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. Please complete the form and return to this center.

**2. Who can receive free meals without providing income information?** Children in households who receive Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) may be eligible for free meals. Foster children and children enrolled in Head Start are automatically eligible for free meals. Children in households participating in WIC may be eligible for free meals.

**3. Who can get reduced price meals?** Your children can receive low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

**4. May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You, or your children, do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

**5. Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

**6. How do I report income information and changes in employment status?** The income you report must be the total gross income, listed by source, for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be eligible for free or reduced price benefits.

**7. What if my income is not always the same?** List the amount that you normally earn. For example, if you normally earn \$1000 each month, but you missed some work last month and only received \$900, write down that you receive \$1000 per month. If you normally receive overtime, include it, but not if you only receive it sometimes.

**8. What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income.

**9. We are in the military, do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them, or on their behalf to the household, will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age, disability, or sexual orientation.

If you have other questions or need help, please talk to our Director.



# FAMIS

**FAMIS** is Virginia's health insurance program for uninsured children. **FAMIS Plus** is Virginia's name for children's Medicaid. Both cover all the medical care growing children need to avoid getting sick, plus the medical care that will help them if they do get sick or get hurt.



## COST TO FAMILY

There are no enrollment costs or monthly premiums. With **FAMIS** most co-payments are just \$2.00 or \$5.00. Some services, like regular check-ups, are free. With **FAMIS Plus**, there are no co-payments for any health service.

## ELIGIBILITY

Children may be eligible for **FAMIS** or **FAMIS Plus** if they:

- Live in Virginia
- Are under age 19
- Are U.S. citizens or legally-residing immigrants
- Live in families meeting **FAMIS** income guidelines (For **FAMIS** only, children must also be currently uninsured)

## SERVICES COVERED

- Well Baby Checkups
- Doctor visits
- Dental care
- Emergency care
- Hospital visits
- Vision care
- Vaccinations
- Mental health care
- Prescription medicine
- Well Child Checkups
- Tests and X-rays
- And much more...

Family Size	Yearly	Monthly
1	\$24,129	\$2,012
2	\$32,657	\$2,722
3	\$41,185	\$3,433
4	\$49,713	\$4,144
5	\$58,241	\$4,854
6	\$66,769	\$5,565
7	\$75,297	\$6,276
8	\$83,825	\$6,986
Additional person add	\$8,528	\$712

\* includes 5% standard disregard.

\*\* gross income is your income before taxes and deductions

## HOW TO APPLY

1. Apply online at [www.commonhelp.virginia.gov](http://www.commonhelp.virginia.gov)
2. Call Cover Virginia at **1-855-242-8282** to apply by phone
3. Visit the local Department of Social Services



Visit [www.coverva.org](http://www.coverva.org) for more information