

Enrollment Checklist

Child's Name: _____

Child's Age and group: _____

Requirements for all children:

- _____ Enrollment Form completed
 - Required first day of enrollment
 - Must be updated annually
- _____ Medical form
 - Required 30 days from initial enrollment
 - Not required for school-aged children
 - Must be updated annually
- _____ Immunization Record
 - Required the first day of enrollment
- _____ Permission to Pick up form
 - Required the first day of enrollment
- _____ Parent Handbook Signoff form
 - Required first day of enrollment
- _____ Special needs form if needed
 - Compare to the back of the enrollment form
 - Required the first day of enrollment
- _____ USDA Income Eligibility
 - Required the first day of enrollment
- _____ SUTQ Family Information
- _____ ASQ
- _____ Photo Release YES _____ NO _____

For Title XX:

- _____ Application
- _____ Employment Verification/School schedule
- _____ 1400
 - Only need 1400 if a change in placement

If under 18 months:

- _____ Infant Information Sheet
- _____ Sleep Waiver
 - If parent wants the child to sleep on side or back
- _____ USDA Infant Meals Form
- _____ Cot Waiver (if between 16-18 months)
- _____ Transition Letter (if between 16-18 months)
- _____ Children between 2 $\frac{1}{2}$ and 3 also need a transition letter

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code	Home Telephone Number		
Parent/Guardian Name #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City			State	Zip	
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell# <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell# <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child		Telephone Number	
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

- No
 Yes - *check all that apply* Food Medication Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

- No
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

- No
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

- No
 Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

- No
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

- No
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No
 Yes - written instructions from the child's health care provider must be on file.
 N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or **medical personnel** in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes <i>(If yes, skip to Emergency Transportation Authorization section)</i>	
<input type="checkbox"/> No <i>(If no, fill out the following:)</i>	
The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every ____ hours.

Emergency Transportation Authorization

<u>Give <i>Permission</i> to Transport</u>	OR	<u>Do Not Give <i>Permission</i> to Transport</u>
Program or Home Name		Program or Home Name
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.	Do not sign both	does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature		Parent's Signature
Date		Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>	
This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.	
Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.			
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	Date of Birth
Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):	
Section A- EXAMINATION	
√ The above named child has been examined.	
√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).	
√ The above named child does not have allergies OR is allergic to the following (<i>please list in space below</i>):	
<i>Check below, if applicable:</i>	
<input type="checkbox"/> Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.	
Optional: Measurements and Recommended Assessments/Screenings	
Height _____	Vision _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Weight _____	Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____
Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (Complete ONLY ONE SECTION below)	
Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases: Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER: <input type="checkbox"/> The above named child has been immunized against the diseases listed above. <i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i>	Initials of Examining Health Care Practitioner Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): <input type="checkbox"/> I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	Signature of Parent Date

Small World Child Care, Inc.

I understand to protect my child I am providing Small World a list of names of people who have my permission to pick up my child. I will notify Small World in advance if of these people will be picking my child up. I understand Small World will not release my child unless a person's name is on the list. There are NO exceptions to this policy. We will accept NO verbal authorization. It must be in writing. All persons on this list must provide staff members with a photo ID on the first visit and may be asked for it again in future pick ups if the staff member is not familiar with the person.

Name

Relationship to Child

Ohio Department of Job and Family Services
CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

<p>This form shall be completed when a child has a condition that requires one of the following:</p> <ul style="list-style-type: none">• Monitoring the child for symptoms which require staff to take action• Ongoing administration of medication or medical foods.• Administering procedures which require staff to be trained on those procedures• Avoiding specific food(s), environmental conditions or activities• School-age child to carry and administer their own emergency medication <p>If the medication is documented on this form, then a JFS 01217 is not required.</p>	
Child's Name	Date of Birth
Special Health Condition	
<p>Does the condition require medication?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p><input type="checkbox"/> Check here if questions 1 through 7 are included on a separate sheet with physician's instructions.</p> <p>1. What are the symptoms to watch for?</p> <p>2. When should the medication or medical food be administered?</p> <p>3. What are the instructions for administration?</p> <p>4. What triggers the need for medication or medical foods?</p>	

5. What are the expected results of the medication or medical foods?

6. What are the actions to be taken if symptoms do not subside?

7. What are the activities, foods, environmental conditions to avoid? Not applicable

Training instructions (*include all steps to administer the medication or perform the medical procedure*)

Included on attached physician's instructions

If expected result of medication or medical food does not occur:

Check here if Emergency Medical Services (9-1-1) is to be contacted

NOTE: If Emergency Medical Services (9-1-1) is to be contacted, the parent/guardian is also to be contacted immediately.

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? (Check all that apply)

Medication Supplies Assistance N/A

Parent Provided Training AND grants permission to perform the procedure	Complete Only One Section	Certified Professional Training AND parent grants permission to perform the procedure	
<i>My signature indicates I have provided training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>		<i>My signature indicates I have provided training for the medical procedure</i>	
Parent Signature		Certified Professional's Name (please print)	
Date of Signature		Certified Professional's Signature	
		Date of Signature	Phone Number
		<i>My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>	
		Parent Signature	
	Date of Signature		

Signatures of all child care staff members who have been trained in performing the procedure for this child.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.

Administrator/Provider Signature	Date of Signature
----------------------------------	-------------------

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

INSTRUCTIONS: To apply for free and reduced-price meals, read the household letter and instructions on backside of this form. Complete application and return to the center, in accordance with the NSLA. Information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if *Part 3* is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME Small World Child Care, Inc.	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)	PART 2 -- LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.
PART 1 -- PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER		
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE
1.	<input type="checkbox"/>	CASE NO. _____
2.	<input type="checkbox"/>	CASE NO. _____
3.	<input type="checkbox"/>	CASE NO. _____
4.	<input type="checkbox"/>	CASE NO. _____

PART 3 -- TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income; list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ amount / how often	\$ amount / how often	\$ amount / how often	\$ amount / how often
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 -- SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Check if applicable) <input type="checkbox"/> I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

State Distribution: July 2021

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion: Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12	Application Certified/Categorized as: <input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household size and income <input type="checkbox"/> Foster Child <input type="checkbox"/> REDUCED, based on Household size and income
Total Household Size: _____ Total Household Income: \$ _____ Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year	<input type="checkbox"/> PAID, based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date (From the first of month of date signed)	Expiration Date (Valid until last day of month in which form was signed one year earlier)
--	---	--	--

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

SNAP/REduced-Price Meals – Child Care Center Worksheet

Please help us comply with the requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income-eligibility application for free and reduced-price meals. This information will be treated with strict confidentiality. The CACFP provides reimbursement for the child care center for healthy meals and snacks served to children enrolled in child care. The completion of the income-eligibility application is optional. Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits. An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced-price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.

PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.

- a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.
- b) Check the box for any person listed as a household member (including children) that has no income.
- c) For each household member, list each type of income received during the last month and list how often the money was received.
 1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and 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.
 2. List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
 3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
 4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

- a) * All applications must have the signature of an adult household member.
- b) * The adult signing the application must also date the form.
- c) * Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

NON-DISCRIMINATION 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: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

REDUCED INCOME ELIGIBILITY GUIDELINES						
Guidelines to be effective from July 1, 2021 through June 30, 2022. Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.						
HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK	
1	23,828	1,986	993	917	459	
2	32,227	2,686	1,343	1,240	620	
3	40,626	3,386	1,693	1,563	782	
4	49,025	4,086	2,043	1,886	943	
5	57,424	4,786	2,393	2,209	1,105	
6	65,823	5,486	2,743	2,532	1,266	
7	74,222	6,186	3,093	2,855	1,428	
8	82,621	6,886	3,443	3,178	1,589	
For each additional family member, add	+8,399	+700	+350	+324	+162	

Ohio Department of Education - Office of Nutrition
**CHILD AND ADULT CARE FOOD PROGRAM
 BIRTHDAY ABILITY FORM**

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be completed annually and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME
(please print)

AGE

BIRTHDATE

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
 AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

SIGNATURE OF
PARENT/GUARDIAN

DATE

DAY PHONE
NUMBER

MAILING ADDRESS:
STREET /APT.

CITY

ZIP CODE

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

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

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

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

This institution is an equal opportunity provider.

Revised 8/2021

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name <i>(Last)</i>	<i>(First)</i>	Nickname <i>(If any)</i>
<p><i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i></p>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. <i>(Check all that apply)</i> How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check all of the words that best describe your child's personality and behavior

- active adventurous affectionate anxious bossy bright busy calm cautious cheerful
 content creative curious easily-angered emotional energetic excitable friendly gives-in-easily
 happy hesitant insecure jealous likes structure/routines loud loving mellow outgoing
 prefers adult attention quiet sensitive serious shares-well social spontaneous stubborn tentative
 other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a high chair, booster, child size chair or adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date

Dear Parents,

We have created a Facebook business page for the center and would like to use pictures of our students on the page. No names will be used just the photos of the kids during some of the activities that we do. Please write your child's name below and sign on the line to either give permission or not to give permission. If you have any questions please see Ms. Beth. Also, please "like" us on Facebook.

Thank You,
Ms. Beth
Administrator

Child's Name _____

I give Small World permission to use my child's photo

X _____

I DO NOT give Small World permission to use my child's photo

X _____

Child Care Center Change Request

FCDJFS #1401-CC (9/11)

Type of Change: Initial Case Termination
 Redetermination Change
 Provider E-mail Address: Smallworldchildcare@yahoo.com

Case Name	First	Middle	Last
Street Address	City		
State	Zip Code		
Case Number	Requested Start Date of Care		
Provider Name <u>Small World Child Care</u>	Provider Address <u>1080 Oberz Rd, Columbus, Oh. 43207</u>	Provider Vendor Number/ State ID <u>25005/404 2009</u>	Full Time/Part Time (FT/PT)
Household Composition	First Name	Last Name	Gender
Male Adult			
Female Adult			
1 st Child			
2 nd Child			
3 rd Child			
4 th Child			
5 th Child			
6 th Child			
7 th Child			
8 th Child			

Instructions for change:

PLEASE READ BEFORE SIGNING: The undersigned child care provider hereby certifies that the information contained herein is true and accurate, and understands that if *(child care provider)* will be held responsible for any overpayment that occurs as a result of having provided inaccurate and/or misleading information. *(To be signed by provider using ink)*

The undersigned parent/customer hereby acknowledges that a Child Care Center Change Request form must be signed in order to initiate services, to add children, and/or to change a schedule, and that the failure to sign may delay or prevent the processing of the change. By signing this form, I certify that the information contained herein is true and accurate, and understand that I will be held responsible for any overpayment that occurs as a result of having provided inaccurate and/or misleading information.

My signature below also serves as authorization for *(Provider Name)* Small World Child Care to provide FCDJFS with information necessary to determine eligibility for publicly funded child care, and/or to monitor or evaluate the delivery of said care. Any information shared pursuant to this document shall remain confidential according to state and federal law. This authorization shall remain in effect, as needed, unless revoked by me in writing. *(To be signed by parent/customer using ink)*

Provider Signature _____ Date _____

Provider Name PRINTED _____ Telephone Number _____

Parent/Customer Signature _____ Date _____

Parent/Customer Name PRINTED _____ Telephone Number _____

*** Documentation of Change MUST be submitted with this form ***



Ohio Department of Job and Family Services
BASIC INFANT INFORMATION FOR CHILD CARE

<p>This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.</p>					
Child's Name			Nickname		
Child's Date of Birth			Siblings		
<p>What are you feeding your infant? <i>(Check all that apply)</i></p> <p><input type="checkbox"/> Formula (include brand) <input type="checkbox"/> Breast milk</p>					
Formula preparation <i>(if center/provider is to prepare.)</i>					
Amount for each feeding			Frequency of feedings		
<p>My infant likes a bottle warmed: <i>(Check one)</i> <input type="checkbox"/> Room temp <input type="checkbox"/> Warm <input type="checkbox"/> Very warm/NOT HOT</p>					
Juice <i>(type, amount, when?)</i>					
Does child use a cup yet? <input type="checkbox"/> No <input type="checkbox"/> Yes					
<p>Solid foods <i>(baby food, brand, types, amounts, frequency)</i> <i>*you must have written permission from your child's physician if your child is under 4 months and given solid foods.</i></p>					
Are foods served room temperature or warmed?					
Table food <i>(types, amounts, frequency, special instructions)</i>					
Security items <i>(pacifier, blankets, etc.)</i>					
Nap schedule					
Hints for getting baby to sleep					
<p>Sleeping Position <input type="checkbox"/> Back <input type="checkbox"/> Side* <input type="checkbox"/> Tummy*</p> <p><i>*You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.</i></p>					
Special Precautions					
Any additional information about your child that would be helpful or you would like staff to know.					
Parent Signature				Date	
Primary Caregiver Signature				Date	
Date form last updated					

CACFP
INFANT MEALS -- PARENT PREFERENCE LETTER

TO: Parents and Guardians of Infants under one year of age

FROM:

Name of Center or Provider	Small World Child Care Inc.
----------------------------	-----------------------------

TOPIC: Who will provide food for your infant's meals?

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a child nutrition program of the United States Department of Agriculture. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to offer formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

Center or provider to insert the NAME OF FORMULA that they will provide	Comforts Sensitive Formula
---	----------------------------

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section.

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

- I want the center or FCC home provider to provide formula for my infant
- I will bring iron fortified infant formula for my infant
- I will bring expressed breast milk for my infant
- I will come to the center or FCC home to breast feed my infant

Parent/Guardian: List Name of Formula You Will Provide
--

Solid Food: (check one)

- I want the center or FCC home to provide solid food for my infant when he/she is developmentally ready for it
- I will bring solid food for my infant when he/she is developmentally ready for it

*Note: If your feeding preferences change, the center or provider will ask you to complete a new form.

INFANT'S NAME:	INFANT'S BIRTHDATE:
PARENT/GUARDIAN SIGNATURE:	DATE:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

What is WIC?

WIC is a nutrition education program. WIC provides nutritious foods that promote good health for pregnant women, women who just had a baby, breastfeeding moms, infants and children up to age 5.

What Does WIC Provide?

- ✓ Nutrition education and support
- ✓ Breastfeeding education and support
- ✓ Referral for health care
- ✓ Immunization screening and referral

✓ Supplemental foods such as:

- Cereal
- Eggs
- Milk
- Whole-grain foods
- Fruits and Vegetables
- Infant formula

Who is Eligible for WIC?

Women who are pregnant, breastfeeding or have a baby less than 6 months old, and infants and children up to 5 years old are eligible to apply for WIC. Fathers are welcome to apply for WIC for their children up to age 5.

To qualify for services you must:

- ✓ Live in Ohio
- ✓ Meet WIC income guidelines
- ✓ Have certain nutritional or health risks

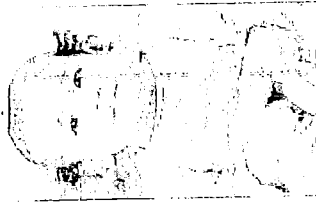
How Do I Apply?

Make an appointment

Call your local clinic to schedule an appointment to meet with a WIC staff member or call 1-800-755-GROW (4769) for locations and more information.

See if you qualify

All it takes is a visit to your local WIC clinic to see if you qualify for services.

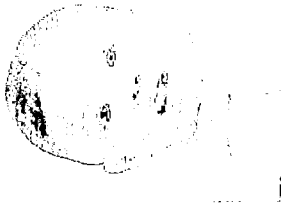
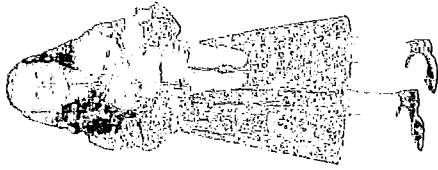
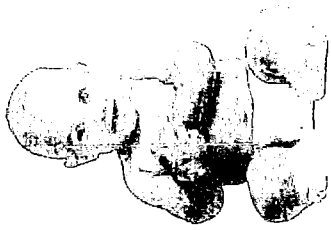


Receive WIC coupons

If you are eligible, you will receive coupons to buy healthy foods at local WIC-approved grocery stores.

What Do I Bring To My First Visit?

- Proof of income (current pay stubs, approval letter for Healthy Start, Ohio Works First, Food Stamps or current Medicaid card)
- Proof of address (utility or credit bill, or Ohio driver's license)
- Proof of identity for you and any other applicants (birth certificate, driver's license, Medicaid card, crib card or shot record)
- All family members applying for WIC services
- If pregnant, a doctor's statement showing due date
- Children's shot records



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, or disability.

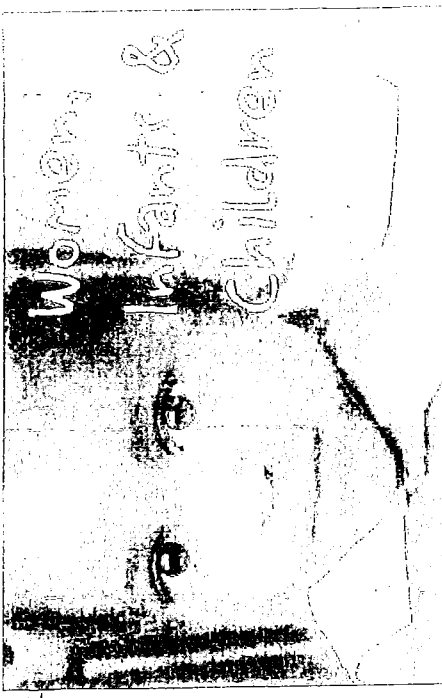
To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

This institution is an equal opportunity provider.



The mission of the WIC program is to improve the health status and prevent health problems among Ohio's at-risk women, infants and children.

Visit our Web site: <http://www.odh.ohio.gov>



Eat Smart, Play Hard



Ohio

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating

Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes:** Licensed private homes.
- **After School Care Programs:** Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters:** Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Ohio Department of Education

Small World Child Care, Inc. 1080 Obetz Rd. Columbus OH 43207 614-491-6070

CACFP Program Specialist 25 S. Front Street, MS 303 Columbus, OH 43215-4183 Phone: 614-466-2945 Toll Free: 1-800-808-6235

Nondiscrimination

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

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