



LifeSpan

Day Care You Can Trust For Children.



Upper Perkiomen School District

Before and After School Care

Enrollment Package

2024-2025

School Year

**Programs offered at Hereford and Marlborough
Elementary School
(also serving 4-5th Grade center students)**



LifeSpan

Day Care You Can Trust For Children.

Dear LifeSpan Families,

Please let me introduce myself and thank you for choosing LifeSpan for your before/after school needs. My name is Nicole Fetherman and I am the Executive Director of all the programs at LifeSpan serving the Upper Perkiomen School District.

Since 1987, LifeSpan has been providing before and after school care for the Quakertown School District. In addition to these programs, we host a full day summer camp. We proudly provide care for approximately 165 children from East Greenville and the surrounding communities.

LifeSpan provides a reliable service for working parents while giving you peace of mind knowing your children are being well cared for in a safe environment. Before and After School Programs have become an extension of the home. LifeSpan takes pride in our caring staff who provide guidance, assist with school work, and provide supervised extra learning opportunities for peer interaction and socialization. All staff complete comprehensive background checks and many are certified teachers.

With our programs being located within the school buildings, this serves nicely to collaborate academic programming with the school district and can reach more children in need of academic support.

LifeSpan's programs are licensed by the Department of Human Services and follow their guidelines for program operation. Our programs participate in Pennsylvania's Keystone STARS quality initiative with all programs rating a STAR 4 quality rating. We strive to continually improve our programs through this voluntary program.

LifeSpan's Program Activities include the following:

- ❖ Collaborative academic programs with the school district
- ❖ Homework supervision
- ❖ Curriculum based activities
- ❖ Organized Games/Active Play
- ❖ Creative Arts/Dramatic Play
- ❖ STEM activities (Science, Technology, Engineering and Math)
- ❖ Breakfast and Snacks
- ❖ Monthly activity calendars and Special Events

Hours of Operation

On regularly scheduled school days the program opens at 6:30 am and runs until the school bell rings. LifeSpan staff will be on site from the time school closes approximately 3:30 p.m. until 6:00 p.m.

- ❖ Delayed openings—8:30 a.m. and remain until the beginning of school day.
- ❖ Early dismissal--will run from dismissal until 6:00 pm unless district decides otherwise
- ❖ In-service/holiday care days:
 - The following in-service days will be held at Hereford Elementary School: 8/30/24, 10/7/24, 10/18/24, 11/25/24, 11/26/24, 2/14/25, 4/17/25, 4/21/25, 6/11/25
 - The following holiday care days will be held at St. Mark's Lutheran Church: 11/5/24, 11/27/24, 11/29/24, 12/23/24, 12/24/24, 12/26/24, 12/27/24, 12/30/24, 12/31/24
 - The following days LifeSpan will be closed: 8/23/24, 9/2/24, 11/28/24, 12/25/24, 1/1/25, 1/20/25, 2/17/25, 4/18/25
 - Pre-Registration sheets will be required for sign up. They will be handled closer to the date of the in-service/holiday care day.
 - Breakfast and snack will be provided on these days, but a packed lunch is required for all students.

*When the UPSD schools close due to severe weather or snow, no care is provided.

LifeSpan takes pride in our reputable history of exceptional service to families. We look forward to a stimulating 2024/2025 school year and learning more about your family.

Sincerely,

Nicole Fetherman
Executive Director
2460 John Fries Highway Quakertown, PA 18951
215-536-9036
215-538-9435 (fax)
nfetherman@lq.org
www.lifespanchildcare.org



LifeSpan

Day Care You Can Trust For Children.

Dear LifeSpan Parents,

This letter is to assure you of our concern for the safety and welfare of children attending LifeSpan. Our Emergency Plan, which is located at each facility, provides for complete response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- Immediate evacuation: students are evacuated to a safe area on the grounds of the facility in the event of a fire, etc.
- In-place sheltering: sudden occurrences, such as weather or hazardous materials related incidents, may dictate that taking cover inside the building is the best immediate response.
- Evacuation: total evacuation of the facility may become necessary if there is a danger in the area. If requested by local authorities, children will be taken to a relocation facility as follows.

LifeSpan at Hereford/Marlborough

LifeSpan Day Care – East Greenville
399 Washington St. East Greenville PA

- Modified Operation - may include cancellation, postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems that make it unsafe for children, but may be necessary in a variety of situations.

Please listen to Channel 69 Storm Center for announcements relaying any of the emergency actions listed above.

We will rely on the telephone as the primary means of notification and communication. Calls can be made to LifeSpan cell phones concerning emergency status using the following numbers:

LifeSpan Day Care – Quakertown	215-536-4417
LifeSpan Day Care - Allentown	267-733-3419
LifeSpan Day Care – E. Greenville	610-216-7170

The form designating persons to pick up your child is included with this letter for you to complete and have returned to the day care facility as soon as possible. This form will be used every time your child is released. Please ensure that only those persons you list on the form attempt to pick up your child. Please feel free to contact the facility director with any questions or concerns.



LifeSpan

Day Care You Can Trust For Children.

Enrollment Application

Date: _____ Child's Birth Date: _____

Child's Name: _____

Parents/Guardians: _____

Mailing Address: _____

Home Number: _____ Cell Number: _____

Work Number: _____ *Email: _____

Facility Child attends: Hereford Elementary Marlborough Elementary 4th/5th Grade enter

Child's Schedule for Care: Full Time (5 days) Part Time (2-4 days)
Drop In (1 day/as needed)

Days Child will be Attending: Monday Tuesday Wednesday
Thursday Friday

School Age Program Only

Grade: _____

Program Interest: Before School After School
Before & After School Holiday/Non-Instructional Days

Location: _____

Select your child's home school:
Hereford Elementary Marlborough Elementary
Other: _____

Where did you hear about us?

Were you referred by someone? _____ If so, by whom? _____

Office Use Only: Deposit _____ Amount _____
Anticipated Start Date _____ Class _____ H M
Form Reviewed & Entered by _____

LIFESPAN SCHOOL AGE RATES - UPSD

2460 John Fries Highway
Quakertown, PA 18951
215-536-4417

EFFECTIVE July 1st, 2024

BEFORE & AFTER SCHOOL CARE	Before	6:30 a.m. to 8:30 a.m.	\$ 30.00	Day
	After	3:00 p.m. to 6:00 p.m.	\$ 30.00	Day
	Before & After	6:30 a.m. to 6:00 p.m.	\$ 45.00	Day
	Drop In	(in addition to daily rate)	\$ 6.00	Day
	Early Dismissal/Delay	(in addition to daily rate)	\$ 12.00	Day
	Holidays/In-service days		\$ 56.00	Day

Annual Registration Fees:

\$75.00 for 1 child

\$100.00 for 2 children

\$125.00 for 3 or more children

Late Fees: \$1.00 per minute after 6:00 p.m.

UPSD will provide bussing to and from 4th/5th grade center to homeschool elementary locations. Contact UPSD transportation for details/concerns.

AGREEMENT

NAME OF CHILD		START DATE	
FEE AMOUNT \$	PER DAY	WEEK	PAYMENT TO BE MADE ON MONDAYS WEEKLY MONTHLY
SERVICES TO BE PROVIDED AS PART OF THE DAY CARE FEE (EXAMPLES: TRANSPORTATION, CARE, MEALS, ETC.)			
FULL TIME	PART TIME	DROP IN	ROOM ASSIGNMENT
MONDAY	TUESDAY	WEDNESDAY	THURSDAY FRIDAY
CARE	MEALS	TRANSPORTATION	DEVELOPMENTAL ASSESSMENTS GIVEN 2 TIMES A YEAR
SCHOOL AGE	PKC		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSONS DESIGNATED BY PARENTS TO WHOM CHILD MAY BE RELEASED	
LATE FEE \$1.00	PER MIN-HR MINUTE		
EXTRA SERVICES TO BE PROVIDED AT AN ADDITIONAL FEE (IF APPLICABLE)		TUITION RATE	
		CHILD CARE WORKS/TITLE XX	
REGISTRATION FEE:		PRE-K COUNTS	
DEPOSIT (Last week of care):		CONTRACTUAL ALLOWANCE	
PROMOTION (Optional):		LQ EMPLOYEE DISCOUNT (FACILITY)	
Payment Method: TE	Check	Cash	Credit Card
		TOTAL DUE WEEKLY	
<p>I, the Parent/Guardian;</p> <p>_____ Received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)</p> <p>_____ Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)</p> <p>_____ Received a copy of the Parent Handbook.</p>			
Signature – Operator		Date	Signature – Parent or Guardian
			Date

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE – PARENT OR GUARDIAN
	DATE

Allergy Posting

Dear parents,

In order to post medical/allergy information about children, staff must obtain written permission from the parent.

Please sign this form stating that Lifespan has permission to post your child's name on our medical/allergy posting.

Thank You, Lifespan

Child's Name: _____

Allergy/Medical Condition: _____

Parent/Guardian Signature: _____

Date: _____

CHILD HEALTH REPORT

(55 PA CODE 563270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): <input type="checkbox"/> NONE
DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. <input type="checkbox"/> NONE
CHILD'S ALLERGIES (DESCRIBE, IF ANY): <input type="checkbox"/> NONE
LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES. <input type="checkbox"/> NONE
IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
VISION (subjective until age 3)							
HEARING (subjective until age 4)							
LEAD							

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.



Automated Payment Processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Form fields for Section A: Cardholder Name, Phone #, Cardholder Address, City, State, Zip, Account Number, Expiration Date, Cardholder Signature, Date.

SECTION B (Bank Account)

Form fields for Section B: Your Name, Phone #, Address, City, State, Zip, Bank or Credit Union Name, Bank or Credit Union Address, City, State, Zip, Routing Transit Number, Account Number, Checking, Savings.

Authorized Signature and Date fields.

For Official Use Only

Form fields for official use: Date Received, Employee Signature.

VOIDED CHECK template with fields for payee information, amount, routing number, account number, and check number.

A service of



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Day Care You Can Trust For Children.

I have received, read and understand the billing policies and procedures as outlined in the attached document for my family's participation in LifeSpan programs.

Family Name _____

Signature _____ Date _____

Please provide an updated email address for program communications, newsletters and notifications and special announcements.

Email: _____

Email: _____

Please return to the front office upon enrollment.



LifeSpan

Day Care You Can Trust For Children.

“GETTING TO KNOW YOU”

We are asking that parents and children involved in our programs participate in a brief survey and questionnaire that will help us create a better understanding of your child, your family and your expectations of our program. We respect and understand your right to privacy and the purpose of this survey is to ensure that your children are receiving the best care possible for each individual child. Please answer the questions honestly and know that your responses will only be reviewed by the director and staff directly involved with the care of your child. Please feel free to contact us to discuss any information you may not be comfortable answering on the survey. If you would prefer to discuss the survey in person with the director and staff, an appointment can be arranged at your convenience.

The first section is general information about your family and life at home. The second section is for you to do with your child. This section will allow us to better understand your child's likes and dislikes which will aid us in designing a program better suited to the preferences of the children within the group. The third section pertains to your child's educational experiences, possible limitations, health and safety issues and general well being. The information you provide here will aid us in providing the most effective environment, learning experiences and appropriate atmosphere for your child to spend their out of school time.

We thank you in advance for your cooperation and the time dedicated to completing the survey. Please return to the office upon completion.

Thank you.

LifeSpan Staff



LifeSpan

Day Care You Can Trust For Children.

Getting to know you-Kindergarten/School-age

Child's Name _____ Date _____

Section 1 - Family Information

Tell us about your family: Does your child have siblings? Are there nicknames that your child uses to refer to his/her self or other family members?

Section 2 - What makes your child happy? Does your child have a particular hobby, collection, or interest that we could tie into our learning to help your child make meaningful connections and share his/her experiences?

Section 3 - Goals for the school year (social, emotional, cognitive) Are there specific areas that you would like to see us strengthen throughout the school year?

Is there an academic area that you feel your child enjoys that you'd like to see us continue to elaborate on this year?

How does your child get along with others? Is he/she shy? Outgoing? A team player? A Leader?

Is your child exceptional in any way?

Section 4: Parent Involvement

Does your schedule allow you to read to the class, speak about your favorite hobby, or help organize parties or class events?

Would you like to schedule a "Getting to Know You" meeting with the Director to discuss your child's needs further?

yes not at this time



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Homework Contract

LifeSpan School Age Programs offers and encourages children to do homework while attending the after school program. Homework help is available daily. Parents are still responsible to check their child's homework to ensure all assignments have been completed properly. Please note below your preferences in regards to homework for your child.

Child's Name _____

- Should complete all assignments
- Should attempt to complete assignments
- Should save homework for home
- OTHER (please specify your preference)

Parent Signature

Date



LifeSpan

Day Care You Can Trust For Children.

Photo Permission Form LifeSpan Release

Of consideration of my engagement as a model, and for other good and valuable consideration herein acknowledged as received, I hereby grant to LifeQuest, his/her heirs legal representatives and assigns, those for whom Photographer is acting, and those acting with his authority, and permission the irrevocable and unrestricted right and permission to take, copyright in his own name or otherwise, and use, reuse and republish photographic portraits or pictures of me or in which I may be included in whole or part, or composite or distorted in character or form without restriction as to changes or alterations, in conjunction with my own or a fictitious name, or reproductions thereof in color or otherwise, made through any medium at his studios or elsewhere, and in any or all media now or hereafter known for illustration, promotion, art editorial, advertising, trade, stock sales, or any other purpose whatsoever, without further compensation. I also consent to the use of any published matter in conjunction therewith.

I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in conjunction therewith or the use to which it may be applied.

I hereby release, discharge and release LifeQuest, his/her heirs, legal representatives and assigns, and all persons acting under his permission or authority or those for whom he is acting, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photograph or in any subsequent processing thereof, as well as any publication thereof, including without limitations any claims for libel or invasion of privacy.

I hereby warrant that I am of legal age and have the right to contract in my name. I have read the above authorization, release, and agreement, prior to its execution, and am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

I Agree

I Disagree

Child's Name

Date

Parent/Guardian Name

Parent/Guardian Signature

Witness _____

CHILD PICKUP AUTHORIZATION

I, _____, authorize LifeSpan School & Daycare to release my child (ren) to the person(s) designated. This is in consonance with the LifeSpan Emergency Plan.

<u>Child(ren) Name(s)</u>	<u>Designated Person(s) Name & Relationship</u>
_____	_____
_____	_____
_____	_____

Parent/Guardian Signature: _____

Date: _____

Note: Parents/Guardians should designate themselves as a designated person. Friends, neighbors and other relatives may also be designated.

Do you have a custody order, restraining order, protection from abuse or other court order that affects your child? Yes No

If yes, LifeSpan must be provided with a copy of the most recent order and all amendments thereto. The orders of the court will be strictly followed. In the absence of a court order on file with LifeSpan, both parents shall be afforded equal access to their child as stipulated by law. LifeSpan cannot, without a court order, limit access of one parent by the other parent, regardless of the reason.

COMMONWEALTH OF PENNSYLVANIA

TO: Parents and/or Guardians
FROM: Site Director
SUBJECT: Nondiscrimination in Services

Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provisions of aides, and the use of alternate service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any parent and/or their guardian, who believes they have been discriminated against, may file a complaint with any of the following:

LifeSpan School and Daycare
399 Washington ST.
East Greenville, PA 18041

Commonwealth of Pennsylvania
DHS Bureau of Equal Opportunity
801 Market Street, Suite 5034
Philadelphia, PA 19107

Department of Human Services
OCDEL, Southeast Region
801 Market Street
Suite 5132 Southeast Regional Office
Philadelphia PA 19107

LifeSpan at Hereford Elementary
1043 Gravel Pike
Hereford, PA 18056

U.S. Dept. of Health and Human Services
Bureau of Equal Opportunity
Room 223 Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

LifeSpan at Marlborough Elementary
1450 Gravel Pike
Green Lane, PA 18054

PA Human Relations Commission
Philadelphia Regional Office
11 N. 8th Street, Suite 501
Philadelphia, PA 19107

LifeSpan serving Fourth/Fifth Grade Center
510 Jefferson St.
East Greenville PA 18041

Parent/Guardian Signature

Date



LifeSpan

Day Care You Can Trust For Children.

Parent Handbook

2024-2025

The LifeSpan Parent Handbook can be found on the LifeSpan Child Care website, under the “For Our Parents” tab. The Parent Handbook contains policies and procedures for all parents to review. The web address is <https://www.lifespanchildcare.org/>

I have been given information about where to find the LifeSpan Parent Handbook. I understand that if I have questions, at any time, regarding the handbook, I will consult with the Executive Director.

Parent’s Signature: _____

Parent’s Printed Name: _____

Child’s Name: _____

Date: _____

**INDIVIDUALIZED EDUCATION PLANS (IEP) AND
INDIVIDUALIZED FAMILY SERVICE PLANS (IFSP)
INFORMATION SHEET**

Because of the diverse set of needs of the children in our program, it is important to gather as much information about the best ways to educate each child. IEP's and IFSP's are created by service providers working with children with special needs and include this information. The Keystone STARS Performance Standards therefore require each early learning provider to request copies of IEP's and IFSP's for the children in their care. Because of the importance of the IEP/IFSP to a child's learning, the program should have a copy before the child begins to attend, if possible.

The information found on an IEP/IFSP is protected by privacy laws including the Health Insurance Portability and Accountability Act (HIPPA). Releases of information may also be required to speak to members of a child's treatment team. Professional development regarding privacy issues, and HIPPA in particular, is highly recommended.

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

Please circle an option below:

I am providing a copy of my child's IEP or IFSP.

I am not providing a copy of my child's IEP or IFSP.

This is not applicable to my child.

Parent/Guardian Signature _____

Printed Name _____ Date _____

EMERGENCY CONTACT/ PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124(a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME		BIIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME NUMBER
ADDRESS		CELL NUMBER
BUSINESS NAME	EMAIL ADDRESS	WORK NUMBER
FATHER'S NAME/ LEGAL GUARDIAN		HOME NUMBER
ADDRESS		CELL NUMBER
BUSINESS NAME	EMAIL ADDRESS	WORK NUMBER
EMERGENCY CONTACT PERSON(S)		PHONE NUMBER WHEN CHILD IS IN CARE
1		
2		
3		
PERSON(S) TO WHOM CHILD MAY BE RELEASED	ADDRESS	PHONE NUMBER
1		
2		
3		
NAME OF CHILD'S PHYSICIAN/ MEDICAL CARE PROVIDER		PHONE NUMBER
PROVIDER ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)	
MEDICAL/ DIETARY INFO NECESSARY IN EMERGENCY SITUATION	MEDICATIONS/SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY FACILITY	WADING	

SIGNATURE OF PARENT OR GUARDIAN

DATE

CHILD CARE REQUEST FORM



STUDENT / PARENT INFORMATION

REQUESTED START DATE: _____

Student Name: _____ School Attending: _____
Grade: _____ Home Address: _____
Parent/Guardian: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____

MORNING REQUEST:

Child Care Provider: _____ Phone Number: _____
Child Care Address: _____
Pick Up from Home: M T W T H F Pick Up From Child Care: M T W T H F

AFTERNOON REQUEST:

Child Care Provider: _____ Phone Number: _____
Child Care Address: _____
Drop off at Home: M T W T H F Drop off at Child Care: M T W T H F

The Upper Perkiomen School District shall transport students in grades K-5 who are picked up or dropped off at a destination other than their home on a daily basis, for the purpose of child care. Transportation will not be provided for any day care facility located within a walking boundary of a school, or located outside of the district. The parent of students in child care must submit a written request to the Transportation Department yearly for review and approval by June 1st of the preceding school year.

The following conditions must also be met:

1. In order to be effective for the beginning of each school year, the Child Care Request Form with parent signature must be submitted by June 1st. Late requests and requests made during the school year, may take up to 2 weeks to complete.
2. Such students must board or disembark at an existing stop on the regularly scheduled bus route. We will not reroute buses to accommodate child care requests.
3. There must be space available on the bus.
4. Such students will be accepted on a first come, first-served basis.
5. Such students may not continue to ride the bus if other students, eligible for transportation under the foregoing provisions, are assigned to the bus causing the bus to reach its rated capacity.
6. All requests must be for a minimum of two weeks.
7. A request to ride an alternate bus, for a temporary situation, will not be issued.
8. Subject to the foregoing, not more than three (3) requests for change in location to accommodate a modification of child-care arrangements may be sought during a school term. Split schedule requests will only be accommodated one (1) time per school year.
9. Eligible stops are accredited child care centers that are within 3 miles of the student's Elementary school boundary; all other stops, family/neighborfriend, must be within the student's Elementary school boundary.

Parent/Guardian Signature: _____ Date: _____

(I have read the policy rules and request the change in accordance with the rules listed above)

**LifeSpan School & Daycare
Authorization to Release Student Records**

I hereby authorize LifeSpan School & Daycare

To send /release the records indicated below to:

Upper Perkiomen School District

Those records checked, if available, may be released:

1. _____ Official Administrative Record (name, address, birth date, classroom/grade level completed, grades, and attendance records)
2. X Health Records including immunization information
3. _____ Child Assessments (Ounce Scale, Work Sampling, Dibels, PALS, Math, Ages and Stage), other developmental screenings.
4. _____ Teacher Observations and Ratings
5. X Confidential Records (individually administered test results and behavioral, psychological, psychiatric and neurological reports, IEP's/IFSP's)
6. X Student Assistance Information (behavior reports, incident reports, referral forms, parent questionnaires, and release of information)
7. X Verbal/phone and email discussion regarding the educational support and care of my child.

Student's Full Name

Signature of Parent or Guardian

Student's Date of Birth

Date

LifeSpan School & Daycare Authorization to Release Student Records

I hereby authorize

Upper Perkiomen School District

To send /release the records indicated below to:

LifeSpan School & Day Care

Those records checked, if available, may be released:

1. _____ Official Administrative Record (name, address, birth date, classroom/grade level completed, grades, and attendance records)
2. X Health Records including immunization information
3. _____ Child Assessments (Ounce Scale, Work Sampling, Dibels, PALS, Math, Ages and Stage), other developmental screenings.
4. _____ Teacher Observations and Ratings
5. X Confidential Records (individually administered test results and behavioral, psychological, psychiatric and neurological reports, IEP's/IFSP's)
6. X Student Assistance information (behavior reports, incident reports, referral forms, parent questionnaires, and release of information)
7. X Verbal/phone and email discussion regarding the educational support and care of my child.

Student's Full Name

Signature of Parent or Guardian

Student's Date of Birth

Date



LifeSpan

Day Care You Can Trust For Children.

**Child and Adult Care Food Program
Enrollment Packet**

2024-2025

2460 John Fries Highway
Quakertown, PA 18951
215-536-4417

1651 N. Cedar Crest Blvd
Allentown, PA 18104
610-435-7833

399 Washington St.
East Greenville, PA 18104
215-679-5940

**Child and Adult Care Food Program
Child Enrollment Form**

Sponsor/Center Name: Lifespan
Agreement #: 300-09-145-5

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	<input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:								<input type="checkbox"/> EARLY MORNING SNACK <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	Enrollment Date: _____ Withdrawal Date: _____									
BIRTH DATE										
AGE										
SECOND CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> EARLY MORNING SNACK <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	Enrollment Date: _____ Withdrawal Date: _____									
BIRTH DATE										
AGE										
THIRD CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> EARLY MORNING SNACK <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	Enrollment Date: _____ Withdrawal Date: _____									
BIRTH DATE										
AGE										
FOURTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> EARLY MORNING SNACK <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	Enrollment Date: _____ Withdrawal Date: _____									
BIRTH DATE										
AGE										
FIFTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> EARLY MORNING SNACK <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	Enrollment Date: _____ Withdrawal Date: _____									
BIRTH DATE										
AGE										

Signature _____

Signature of Parent or Guardian

Date _____

Telephone Number of Parent or Guardian _____

CHILD CARE REPRESENTATIVE USE ONLY: Effective Date of This Enrollment Form: _____

Name of Representative/Signature _____

Date _____

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This portion of the form can be used to capture multi-year annual updates.

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or**
- 2. fax:**
(833) 256-1665 or (202) 690-7442; or
- 3. email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility Form Instructions **July 1, 2024-June 30, 2025**

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care home or center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us at:

Lifespan Phone # _____

Step 1:

List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes*, mark the correct boxes next to the child's name and go to Step 4.

Step 2:

You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered *Yes* in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

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How do you report income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write 0 in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children don't have to be U.S. citizens to qualify for meal benefits.
You are in the military	Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

CACFP Meal Benefit Income Eligibility Form
Sharing Information with Medicaid and SCHIP
July 1, 2024-June 30, 2025

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to*. Medicaid and SCHIP *only* use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

No! I do not want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name:

Child's Name:

Child's Name:

Child's Name:

Today's Date:

Print Your Name:

Address:

Signature of Parent or Guardian:

If you have questions or need help, please contact **Craig Kunsman** at **484-243-0619** or **Ckunsman@lq.org**.

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**CACFP Meal Benefit Income Eligibility Form
Letter to Parents (Non-Pricing Centers)
July 1, 2024-June 30, 2025**

July 9, 2024

Dear Parent or Guardian:

LIFESPAN offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). **LIFESPAN** receives support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2024 - June 30, 2025		
Household size	Yearly Income	Monthly Income
1	\$27,861	\$2,322
2	\$37,814	\$3,152
3	\$47,767	\$3,981
4	\$57,720	\$4,810
5	\$67,673	\$5,640

Please fill out a *CACFP Meal Benefit Income Eligibility* form. It will help us find out how much support **LIFESPAN** receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms. Please send the completed form to:

**2460 John Fries Hwy, Quakertown, PA 18951
399 Washington St. East Greenville, PA 18041
1651 N. Cedar Crest Blvd. Allentown, PA 18104**

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability. If you have questions or need help, please contact **Nicole Fetherman** at **215-536-9036** or **nfetherman@lq.org**.

Sincerely,

Nicole Fetherman M.Ed.

**Nicole Fetherman M.Ed.
Executive Director**

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This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility (Child Care)

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

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

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

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDIPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3) **CASE NUMBER:** _____
Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Children listed in STEP 1 here.

Child Income \$ _____
How often? Weekly Bi-Weekly Monthly Bi-Monthly

B. All Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents). If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members (First and last)	Earnings from Work				Welfare/Child Support/Alimony	How often?				Pensions/Retirement/Social Security/SSI/VA Benefits	How often?			
	Weekly	Bi-Weekly	Monthly	2x Month		Weekly	Bi-Weekly	Monthly	2x Month		Weekly	Bi-Weekly	Monthly	2x Month
\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Household Members (Children and Adults) _____
Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member:
Check if no SSN

STEP 4 Contact information and adult signature. This form is not valid without signature and date of adult household member

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form _____ Signature of Adult _____ Today's Date _____
Address _____ City _____ State _____ Zip _____ Phone/Email _____

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages
Social Security <ul style="list-style-type: none"> - Disability Payments - Survivors Benefits 	<ul style="list-style-type: none"> A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	<ul style="list-style-type: none"> A friend or extended family member regularly gives a child spending money
Income from any other source	<ul style="list-style-type: none"> A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	Public Assistance/Alimony/Child Support	Pensions/Retirement/All other sources of income
<ul style="list-style-type: none"> Salary, wages, cash bonuses Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of 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 FDPIR 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 the meal reimbursement for your child care center/provider. 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.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this Institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

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To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442;
EMAIL: or program.intake@usda.gov.

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

For Official CACFP Sponsor Use Only NOT VALID WITHOUT DETERMINING OFFICIAL'S SIGNATURE AND DATE

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income How often? Household size Eligibility

Weekly Bi-Weekly Monthly 2x Month

Categorical Eligibility Free Reduced Denied

Determining Official's Signature _____ Date _____ Confirming Official's Signature (second check) _____ Date _____ Follow-up Official's Signature (For Pricing Institutions - Verification Official) _____ Date _____

Effective Date: If the Institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month.



Children and Adults with Disabilities and Special Dietary Needs

Operators of the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP) are required to make reasonable modifications to Program meals or the meal service to accommodate children or adults (Program participants) with disabilities that restrict the diet.

1. Licensed Medical Authority's Statement for Participants with Disabilities

U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in Program meals for participants whose disabilities restrict their diets. Sponsors, centers, and day care homes must provide modifications for participants on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for Child Nutrition Programs") may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in Pennsylvania includes a:

- Physician,
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the participant's physical or mental impairment restricts the diet;
- An explanation of what must be done to accommodate the participant; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Special Dietary Needs

Program operators may make food substitutions for individual participants who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Program operators are encouraged, but not required, to have documentation on file when making menu modifications within the meal pattern.

Special dietary needs and requests such as those related to general health concerns and personal preferences are not disabilities and are optional for Program operators to accommodate. Meal modifications for non-disability reasons are reimbursable provided that these meals adhere to Program regulations.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008*, a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Children and Adults with Disabilities and Special Dietary Needs

4. Individuals with Disabilities Education Act

Preschool children, infants, and toddlers with disabilities have additional rights under the *Individuals with Disabilities Education Act* (IDEA). Questions regarding the IDEA's requirements should be directed to the U.S. Department of Education, which is the federal agency responsible for the administration and enforcement of the IDEA.

Child Nutrition Program (CACFP/SFSP) Contact

For more information about requesting accommodations to Program meals and the meal service for participants with disabilities, contact:

Click here to enter local contact name and information.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov.

This institution is an equal opportunity provider.

Medical Plan of Care for Child Nutrition Programs (CACFP and SFSP)

Please read pages 1 and 2 before completing this form.

Participant's Name	Date of Birth	Age/Classroom
Name of Center/Program/Site		
Name of Parent/Guardian or Participant's Representative	Phone Number of Parent/Guardian/Representative	
Signature of Parent/Guardian or Participant's Representative	Date	
1. Provide an explanation below of how the participant's physical or mental impairment restricts the participant's diet:		
2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the participant's needs:		
3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. <u>Foods to be omitted:</u>		
<u>Suggested substitutions:</u>		
4. Indicate texture modifications, if applicable: <input type="checkbox"/> Chopped/Cut into bite-sized pieces <input type="checkbox"/> Diced/Finely Ground <input type="checkbox"/> Pureed <input type="checkbox"/> Other:		
5. List any required special adaptive equipment:		
Name of Physician/Medical Authority & Title (Please Print)		Provider Phone Number
Signature of Physician/Medical Authority		Date
<p><i>Signing the following section is optional but may prevent delays by allowing the Program to speak with the physician/medical authority.</i></p> <p>Health Insurance Portability and Accountability Act Waiver In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of the participant as is necessary for the specific purpose of Special Diet information to _____ (center/program/site) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning the participant with the childcare/adult care/summer food program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for the participant. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.</p> <p>The undersigned certifies that he/she is (circle one): Parent Guardian Adult participant or Representative of participant listed on this document and has the legal authority to sign on behalf of that person.</p> <p>Signature: _____ Date: _____</p>		

How does CACFP work?

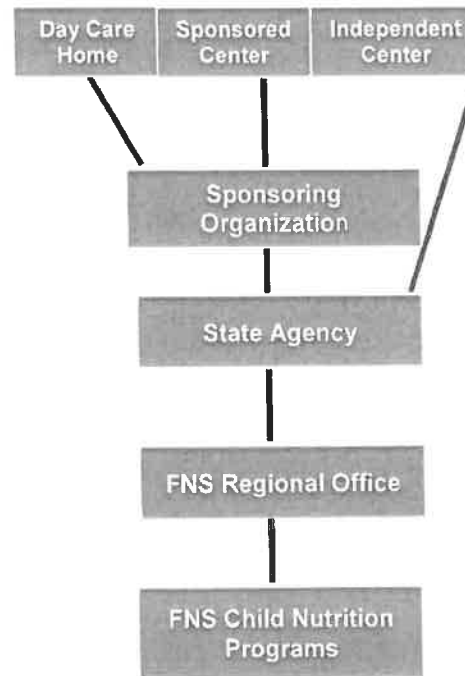
Day care homes and centers receive money for serving nutritious meals. The Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA) oversees CACFP.

States approve sponsors and centers to operate the program. States also monitor and provide training and guidance to make sure CACFP runs right.

Sponsoring organizations support day care homes and centers with training and monitoring. All day care homes participate in CACFP through a sponsor.



CACFP Partners



Contacts

Here is space for the State agency and sponsoring organization to add contact information.



FNS-319
October 2019
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employer and lender.

Building for The Future



In the Child and Adult Care Food Program (CACFP)

Building for the Future in the CACFP

What is CACFP?

CACFP is the Child and Adult Care Food Program. It is a Federal program that pays for healthy meals and snacks for children and adults in day care.

CACFP improves the quality of day care. It makes the cost of day care cheaper for many low-income families.

Besides providing meals in day care, CACFP makes afterschool programs more appealing to at-risk children and youth. Serving afterschool meals and snacks attracts students to learning activities that are safe and fun.

Children and youth who are homeless can also receive meals at shelters that participate in CACFP.

Here is space for the State agency and sponsoring organization to add contact information.

Who is eligible for CACFP meals?

- Children under age 13,
 - Migrant children under age 16,
 - Children and youth under age 19 in afterschool programs in low-income areas,
 - Children and youth under age 19 who live in homeless shelters, and
 - Adults who are impaired or over age 60 and enrolled in adult day care
-

What kinds of meals are served?

CACFP meals follow USDA nutrition standards.

- Breakfast consists of milk, fruits or vegetables, and grains.
- Lunch and Supper require milk, grains, meat or other proteins, fruits, and vegetables.
- Snacks include two different servings from the five components: milk, fruits, vegetables, grains, or meat or other proteins.

Where are CACFP meals served?

Many types of facilities participate in CACFP.

Child Care Centers:

Licensed child care centers and Head Start programs provide day care with meals and snacks to large numbers of children.

Outside-School-Hours Care Centers:

Licensed centers offer before or afterschool care with meals and snacks to large numbers of school-aged children.

Family Day Care Homes:

Licensed providers offer family child care with free meals and snacks to small groups of children in private homes.

"At-Risk" Afterschool Care Programs:

Centers in low-income areas provide learning activities with free meals and snacks to school-age children and youth.

Emergency Shelters:

Homeless, domestic violence, and runaway youth shelters provide places to live with free meals for children and youth.

Adult Day Care Centers:

Licensed centers provide day care with meals and snacks to enrolled adults.

Did YOU KNOW?

- Even if you receive SNAP, MA or TANF, you may also apply for WIC.
- In most instances, WIC has higher income guidelines than SNAP, MA or TANF. Even if you don't qualify for these programs, you may qualify for WIC.
- Most families in Head Start and Early Head Start qualify for WIC.
- Foster children under age 5 qualify for WIC. Foster parent income is not considered.
- WIC does not require proof of citizenship.

WIC Income Guidelines

Household Size	*Monthly (Approx.)
1	\$2,322
2	\$3,152
3	\$3,981
4	\$4,810

For each additional family member, add:

\$830

*Income (before taxes) is effective July 1, 2024. For each unborn infant, add one to household size.



How DO I APPLY?

Get started online at pawic.com or call

**1-800-WIC-WINS
(1-800-942-9467).**



www.health.pa.gov
www.pawic.com



Choose Healthy.
Choose WIC!



PA WIC is funded by the USDA.
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HDWICOR.006

Rev. 7/24



**1-800-WIC-WINS
www.pawic.com**

What IS WIC?

WIC is the Special Supplemental Nutrition Program to help improve the health of women, infants and children. WIC services are provided at no cost to you and your family.

“WIC has helped me make healthier choices for my child, and I can save on my grocery bill.” -- WIC Mom

Who IS ELIGIBLE?

- Women who are pregnant, breastfeeding or recently had a baby (under 6 months)
- Infants
- Children under age 5

You must live in Pennsylvania, have a nutrition need and not exceed the income guidelines.

WIC is for married and single parents, working families and the unemployed. If you are a father, mother, foster parent or other legal guardian of a child under age 5, you can apply for WIC for your child.

How CAN WIC HELP MY FAMILY?

Offers screenings and referrals to health care and other services

- Iron testing for anemia
- Immunization, health and lead screenings
- Referrals for SNAP, MA, TANF, CHIP, Healthy Beginnings Plus, Head Start, food banks, etc.

Gives advice for healthy eating

- One-on-one nutrition education
- Nutrition materials
- Online information

Supports breastfeeding

Breastfeeding provides many health, nutritional, economical and emotional benefits to mother and baby. WIC helps mothers continue breastfeeding even if they return to work.

Provides healthy food

- ✓ Milk
- ✓ Cheese
- ✓ Yogurt
- ✓ Soy-based beverages
- ✓ Tofu
- ✓ Fruits and vegetables (fresh, frozen or canned)
- ✓ Dried or canned beans/peas
- ✓ Eggs
- ✓ Peanut butter
- ✓ Canned fish
- ✓ Juice
- ✓ Cereal
- ✓ Whole grains (bread, tortillas, oats, brown rice and pasta)
- ✓ Infant foods
- ✓ Formula and medically necessary supplements

