



# Stepping Stones Learning Centers

5545 Brookview Drive  
Sachse, Texas 75048  
(972) 530-7840 phone

[www.SteppingStonesLearningCenters.com](http://www.SteppingStonesLearningCenters.com)

## Enrollment Application

We are required by the State of Texas to maintain certain documents and to operate in a safe manner. Accurate and up-to-date information is necessary, should we need to contact you quickly in the event of an urgent situation or an emergency. The information requested in this Enrollment Application allows us to meet these requirements so we can operate in a safe and efficient manner.

**If you have any questions, please let us know before you sign these pages.**

By signing this form, you are agreeing to the following:

1. Keep the information in this Enrollment Application current and up to date
2. Read and accept the rules and regulations found in the current Parent Handbook
3. Pay tuition on time. Tuition is **due on Monday** of each week. If it is not paid by Wednesday of the week it is due, there will be a \$20.00 late charge added
4. Maintain a current credit/debit card or draft form on hand and allow us to it to collect payment should tuition not be paid by Thursday of the week is it due
5. Not bring your child if tuition becomes past due for two weeks
6. Understand that **Weekly rates are charged whether your child attends or is absent for any reason – unless you have completed at least 1 week in advance a change of billing method form**
7. Accurately log in and out each day and to pay a \$1.00 per incident if this is not done
8. Call one day ahead if your child will not be in attendance, or in the event of illness or other emergency, as soon as possible
9. Call by noon if you need/do not need your child picked up from school on an unscheduled event – except in emergencies
10. Give us at least one week's notice if you withdraw your child
11. Give permission for photos and videos of your child to be made during school events and for us to use those images in advertisements and in other media productions without compensation of any kind.
12. Discuss any issues with one of the directors immediately that you feel are of urgent or serious concern
13. Complete all documents in Family Enrollment Packet

Your child's name(s) \_\_\_\_\_

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Received by: \_\_\_\_\_ Date \_\_\_\_\_

# AUTHORIZATION FOR EMERGENCY MEDICAL CARE AUTORIZACION PARA ATENCION MEDICA DE EMERGENCIA

**If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give my permission for:**

Si en caso de alguna enfermedad o accidente no me pueden localizar para arreglar atención médica de emergencia para mi niño, doy permiso para que:

**Name of Day Care Facility Owner or Director**  
Nombre del Dueño o Director del Centro de Cuidado de Niños  
Cheryl Baker or Christa Tillman  
Stepping Stones Brokview, Sachse, Texas 75048

**to take my child (or children):**

a que lleve a mi niño (o mis niños):

<b>Name of Child (1)/Nombre del Niño (1)</b>	<b>Name of Child (2)/Nombre del Niño (2)</b>
<b>Name of Child (3)/Nombre del Niño (3)</b>	<b>Name of Child (4)/Nombre del Niño (4)</b>

**to:**

a:

<b>Name of Doctor/Nombre del Doctor</b>	<b>Telephone No./Teléfono</b>
<b>Address of Doctor/Dirección del Doctor</b>	

**or to:**

o a:

<b>Name of Hospital or Clinic/Nombre del Hospital o Clínica</b>	<b>Telephone No./Teléfono</b>
<b>Address of Hospital or Clinic/Dirección del Hospital o Clínica</b>	

<p><b>I give consent for necessary emergency treatment when my child is in the care of this physician or hospital or clinic.</b></p>	<p>Doy mi consentimiento para el tratamiento médico necesario estando mi niño bajo la atención de este doctor u hospital o clínica.</p>
<p>_____</p> <p><b>Signature-Parent or Legal Guardian</b> Firma-Padre o Tutor</p>	<p>_____</p> <p><b>Date/Fecha</b></p>



# Stepping Stones Learning Center

5804 Billingsley Street  
Sachse, Texas 75048  
(972) 675-0122 phone  
(972) 675-0124 fax  
**www.sslc.tv**

# ENROLLMENT APPLICATION

DATE \_\_\_\_\_

PLEASE PRINT LEGIBLY

**RESPONSIBLE PERSON:** This person is responsible for payment of this account.

FULL NAME FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

MOTHER  FATHER  OTHER \_\_\_\_\_ SS# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

PHYSICAL ADDRESS STREET \_\_\_\_\_ APT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

E-MAIL HOME \_\_\_\_\_ WORK \_\_\_\_\_ OTHER \_\_\_\_\_

WORK BUSINESS NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

PARENT'S MARITAL STATUS \_\_\_\_\_ CHILD(REN) LIVE(S) WITH \_\_\_\_\_

**ADDITIONAL RESPONSIBLE PERSON** (usually other parent)

FULL NAME FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

MOTHER  FATHER  OTHER \_\_\_\_\_ SS# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

PHYSICAL ADDRESS STREET \_\_\_\_\_ APT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

WORK BUSINESS NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

### CHECK ONE BOX IN EACH LINE

TRANSPORTATION  I GIVE  DO NOT GIVE MY CONSENT FOR MY CHILD(REN) TO BE TRANSPORTED BY THIS FACILITY.

WATER ACTIVITIES  I GIVE  DO NOT GIVE MY CONSENT FOR MY CHILD(REN) TO PARTICIPATE IN WATER ACTIVITIES.

FIELD TRIPS  I GIVE  DO NOT GIVE MY CONSENT FOR MY CHILD(REN) TO PARTICIPATE IN FIELD TRIPS.

### MEDICAL INFORMATION

FAMILY PHYSICIAN NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

PREFERRED HOSPITAL NAME \_\_\_\_\_ CITY \_\_\_\_\_ TELEPHONE \_\_\_\_\_

IN THE EVENT THAT I CANNOT BE REACHED TO MAKE ARRANGEMENTS FOR EMERGENCY MEDICAL ATTENTION, I AUTHORIZE THE DIRECTOR OR PERSON IN CHARGE TO SECURE ANY AND ALL NECESSARY EMERGENCY MEDICAL CARE FOR MY CHILD.

IMMUNIZATION RECORDS  I WILL PROVIDE (OR HAVE MY PHYSICIAN'S OFFICE PROVIDE) IMMUNIZATION RECORDS WITHIN TEN DAYS.

OR  MY CHILD(REN) ATTEND(S) THE SCHOOL(S) LISTED BELOW, AND THEY HAVE CURRENT IMMUNIZATION RECORDS.

SCHOOL(S) \_\_\_\_\_

MY CHILD(REN) HAS(HAVE) BEEN EXAMINED WITHIN THE PAST YEAR BY A LICENSED PHYSICIAN AND IS(ARE) ABLE TO PARTICIPATE IN THE DAY CARE PROGRAM.

PASSWORD FOR EMERGENCY VERIFICATION \_\_\_\_\_ HINT QUESTION \_\_\_\_\_

I ACKNOWLEDGE RECEIPT OF THE FOLLOWING:  PARENT HANDBOOK  DISCIPLINE POLICY  BUS RULES  AGREEMENT W/STEPPING STONES LEARNING CENTER

I AGREE TO KEEP THIS ACCOUNT PAID AND CURRENT, AND TO MAINTAIN CURRENT INFORMATION ON FILE.

SIGNATURE \_\_\_\_\_

(MUST BE PARENT OR LEGAL GUARDIAN)

DATE \_\_\_\_\_

**CHILDREN**

C FULL NAME FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ BIRTHDAY \_\_\_\_\_  
 H (CIRCLE ONE) BOY GIRL (CIRCLE ONE) FULL-TIME PART-TIME IF PART-TIME, CIRCLE DAYS: M T W Th F  
 I  
 L SCHOOL \_\_\_\_\_ NEED OUR BUS (CIRCLE ONE) YES NO ALLERGIES \_\_\_\_\_  
 D  
 1

C FULL NAME FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ BIRTHDAY \_\_\_\_\_  
 H (CIRCLE ONE) BOY GIRL (CIRCLE ONE) FULL-TIME PART-TIME IF PART-TIME, CIRCLE DAYS: M T W Th F  
 I  
 L SCHOOL \_\_\_\_\_ NEED OUR BUS (CIRCLE ONE) YES NO ALLERGIES \_\_\_\_\_  
 D  
 2

C FULL NAME FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ BIRTHDAY \_\_\_\_\_  
 H (CIRCLE ONE) BOY GIRL (CIRCLE ONE) FULL-TIME PART-TIME IF PART-TIME, CIRCLE DAYS: M T W Th F  
 I  
 L SCHOOL \_\_\_\_\_ NEED OUR BUS (CIRCLE ONE) YES NO ALLERGIES \_\_\_\_\_  
 D  
 3

C FULL NAME FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_ BIRTHDAY \_\_\_\_\_  
 H (CIRCLE ONE) BOY GIRL (CIRCLE ONE) FULL-TIME PART-TIME IF PART-TIME, CIRCLE DAYS: M T W Th F  
 I  
 L SCHOOL \_\_\_\_\_ NEED OUR BUS (CIRCLE ONE) YES NO ALLERGIES \_\_\_\_\_  
 D  
 4

**ONLY PEOPLE LISTED HERE ARE ALLOWED TO CHECK-IN/CHECK-OUT YOUR CHILDREN**

RESPONSIBLE PERSON				
FIRST	LAST	TDL#	RELATION	FATHER MOTHER GRANDPARENT OTHER
1. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
2. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
3. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
4. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
5. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
6. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
7. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
8. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND
9. FIRST _____	LAST _____	TDL# _____	RELATION	FATHER MOTHER GRANDPARENT FRIEND

FOR OFFICE USE: CODE

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

**EMERGENCY CONTACTS (CAN BE CONTACTED IN THE EVENT OF ILLNESS AND/OR EMERGENCY AND ALLOWED TO MAKE DECISIONS)**

1. FIRST \_\_\_\_\_ LAST \_\_\_\_\_ RELATION FATHER MOTHER GRANDPARENT OTHER \_\_\_\_\_  
 TELEPHONE HOME \_\_\_\_\_ CELL \_\_\_\_\_ OTHER \_\_\_\_\_

2. FIRST \_\_\_\_\_ LAST \_\_\_\_\_ RELATION FATHER MOTHER GRANDPARENT OTHER \_\_\_\_\_  
 TELEPHONE HOME \_\_\_\_\_ CELL \_\_\_\_\_ OTHER \_\_\_\_\_

3. FIRST \_\_\_\_\_ LAST \_\_\_\_\_ RELATION FATHER MOTHER GRANDPARENT OTHER \_\_\_\_\_  
 TELEPHONE HOME \_\_\_\_\_ CELL \_\_\_\_\_ OTHER \_\_\_\_\_

I UNDERSTAND THAT TUITION IS DUE ON MONDAY OF EACH WEEK, IN ADVANCE, FOR THAT WEEK.  
 IT IS LATE AFTER WEDNESDAY. A CHARGE OF \$20.00 WILL BE POSTED EACH THURSDAY IF THERE IS ANY BALANCE DUE.  
 IF I HAVE SELECTED WEEKLY PAYMENT RATES, I UNDERSTAND THAT TUITION IS DUE WHETHER MY CHILD(REN) ATTEND OR ARE ABSENT FOR ANY REASON.

HOW DID YOU HEAR ABOUT STEPPING STONES LEARNING CENTER? \_\_\_\_\_

WHY DID YOU CHOOSE TO ENROLL YOUR CHILD(REN) AT STEPPING STONES LEARNING CENTER? \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(SAME PERSON AS PREVIOUS PAGE)



# Stepping Stones Learning Centers

5804 Billingsley Street  
Sachse, Texas 75048  
(972) 675-0122 phone  
(972) 675-0124 fax

5545 Brookview Drive  
Sachse, Texas 75048  
(972) 530-7840 phone  
(972) 530-9795 fax

## PAYMENT OPTIONS

We offer several methods of paying your tuition:

1. Check, money order, or cash in our office or mailed (not cash) to our office
2. Credit or Debit card in either of our offices
3. Credit or Debit card or online check via our website
4. Credit, Debit, or Bank Draft we post weekly

We do require that you provide a current, valid credit or debit card or a valid check authorization form in the event tuition falls behind.

**Tuition is due on Monday of each week for that week. Tuition is LATE if not paid by the close of business on Wednesday of each week.**

**There is a \$20.00 late charge posted on Thursday of the week payment is due if the payment is late.**

A charge will be posted for the tuition and all outstanding fees due on Thursday using the method you authorize here.

I authorize Stepping Stones Learning Center to charge my account for the amount of tuition and other fees due if my account becomes past due. The method of payment to be used is

\_\_\_\_\_ Credit or Debit card      \_\_\_\_\_ Bank Draft

The card or account information to be used is found on the following page.

---

Signature of authorized person

---

Date signed

## CREDIT/DEBIT CARD DRAFT AUTHORIZATION FORM

This form is to authorize Stepping Stones Learning Center to charge your credit/debit account for tuition and other fees at Stepping Stones Learning Center.

Credit/Debit card # \_\_\_\_\_

Name on credit/debit card account \_\_\_\_\_

Expiration Date on the card \_\_\_\_\_

Last three numbers on back of the card \_\_\_\_\_

Mailing address Zip Code \_\_\_\_\_

## BANK DRAFT AUTHORIZATION FORM

This form is to authorize Stepping Stones Learning Center to draft your bank account for tuition and other fees at Stepping Stones Learning Center.

Name on checking account \_\_\_\_\_

Routing number 9 digits \_\_\_\_ \_ \_ \_ \_ \_ \_ \_ \_

Account number \_\_\_\_\_

Name (if different) of account at Stepping Stones Learning Center

where funds are to be applied: \_\_\_\_\_

Your login code \_\_\_\_\_ (4 digit code you use to sign in/out at SSLC)

**Current charges are normally made on Monday of each week and are for the tuition, fees, and any balances due PLUS tuition and fees for the current week.**

**Charges are normally posted on Thursday for past due balances.**

**Thank you for selecting Stepping Stones Learning Center to care for your child(ren) and for selecting this payment process to keep your account current.**

X \_\_\_\_\_  
Signature as used on this credit/debit checking account      Date

I approve these charges to be made by Stepping Stones Learning Center.



# Stepping Stones Learning Centers

5545 Brookview Drive  
Sachse, Texas 75048  
(972) 530-7840 phone  
(972) 530-9795 fax

[www.SteppingStonesLearningCenters.com](http://www.SteppingStonesLearningCenters.com)

## Food Program Enrollment Form

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

Child's Birth date \_\_\_\_\_ Current age \_\_\_\_\_

Admission date \_\_\_\_\_

Withdrawal date \_\_\_\_\_

1. Circle the days your child will **NORMALLY** attend Stepping Stones

Mon    Tue    Wed    Thu    Fri

2. Circle meals **NORMALLY** served to your child at the center

Breakfast    Lunch    PM Snack

3. What hours will your child **NORMALLY** be attending Stepping Stone?

\_\_\_\_\_ until \_\_\_\_\_

\_\_\_\_\_  
Parent's signature

\_\_\_\_\_  
Date

Thank you for taking the time to complete this form. All information will be kept confidential at the sponsor's office.



Name of Facility/Nombre del centro Stepping Stones Brookview	Facility Representative/Representante del centro	Area Code and Telephone No./Clave del área y teléfono
Address of Facility/Dirección del centro		

Stepping Stones Brookview 5545 Brookview Drive Sachse, Texas 75048 972-530-7840
------------------------------------------------------------------------------------------

Date/Fecha
------------

**Dear Parent or Guardian:**

**We serve nutritious meals to all children enrolled in this facility. We receive federal support to help pay the cost of the meals. Therefore, we do not charge separately for the meals. The amount of federal support we receive is based on information you provide from your child's Head Start, Early Head Start or Even Start Program, or on the information you provide on the enclosed application.**

**HEAD START OR EARLY HEAD START PARTICIPATION: If your child is enrolled as a participant in a Head Start Program or Early Head Start Program, your child is automatically eligible for free meals in the Child and Adult Care Food Program, and Summer Food Service Program without further application. You may ask your child's Head Start Program or Early Head Start Program to give you a letter which certifies that your child is currently enrolled as a participant in Head Start or Early Head Start. If you provide us with a copy of the certification letter from Head Start or Early Head Start, you will not need to fill out the enclosed application.**

**EVEN START PARTICIPATION: If your child is enrolled as a participant in the Even Start Family Literacy Program and has not yet entered kindergarten, your child is automatically eligible for free meals in the Child and Adult Care Food Program, and Summer Food Service Program (closed enrolled sites only) without further application. You may ask your child's Even Start Program to give you a letter which certifies that your child is currently enrolled as a participant in Even Start and has not yet entered kindergarten. If you provide us with a copy of the certification letter from Even Start, you will not need to fill out the enclosed application.**

**If you have not provided us with a Head Start, Early Head Start or Even Start certification letter for your child, and your household income is at or below the income levels shown on Form H1625-A, please fill out this application, sign it and return it to us. Please answer all the questions on the form. *If information about household members and income is missing, federal support may be reduced.***

Estimado padre, madre o tutor:

Servimos comidas nutritivas a todos los niños inscritos en este centro. Recibimos fondos federales que ayudan a pagar el costo de las comidas. Por eso, no cobramos aparte por las comidas. La cantidad de fondos federales que recibimos se basa en la información que usted da sobre el Programa Head Start, Early Head Start o Even Start de su hijo o en la solicitud adjunta.

**PARTICIPACIÓN EN HEAD STARA O EARLY HEAD START.** Si su hijo está inscrito en un programa Head Stara o un programa de Early Head Start, el niño automáticamente llenará los requisitos para recibir comidas gratis en el Programa de Alimentos para Centros de Cuidado de Adultos y Niños, y el Programa de Servicio de Comidas de Verano sin tener que hacer otra solicitud. Puede pedirle al programa Head Start o al programa Early Head Stara de su hijo que le dé una carta en la que certifique que su hijo está inscrito actualmente en el programa Head Start o Early Head Start como participante que llena los requisitos por ingresos. Si nos manda una copia de la carta de certificación de Head Stara o Early Head Start, no tendrá que llenar la solicitud adjunta.

**PARTICIPACIÓN EN EL PROGRAMA EVEN START.** Si su hijo está inscrito en el Programa de Alfabetización de la Familia Even Start y todavía no ha entrado a kinder, el niño automáticamente llenará los requisitos para recibir comidas gratis en el Programa de Alimentos para Centros de Cuidado de Adultos y Niños, y el Programa de Servicio de Comidas de Verano (solamente en sitios cerrados inscritos) sin tener que hacer otra solicitud. Puede pedirle al programa Even Start de su hijo que le dé una carta en la que certifique que su hijo está inscrito actualmente en el programa Even Start como participante y todavía no ha entrado a kinder. Si nos manda una copia de la carta de certificación de Even Start, no tendrá que llenar la solicitud adjunta.

Si no ha presentado una carta de certificación de Head Stara, Early Head Start o Even Start para su hijo, y los ingresos de su unidad familiar no son mayores de los que están enumerados en la Forma H1625-A adjunta, favor de llenar, firmar y enviarnos esta solicitud. Por favor, dé toda la información solicitada en la forma. *Si falta información sobre los miembros o ingresos de la unidad familiar, puede reducirse la asistencia federal.*

**COMPLETE APPLICATION:** For an application to be complete, you must include (1) the names of children enrolled, (2) total household income by source, (3) all household members' names, (4) the Social Security number of the adult household member signing the application or an indication that the household member does not possess a Social Security number, and (5) an adult household member's signature. TANF/Food Stamp households must provide only the children's names, their case number and an adult household member's signature.

**VERIFICATION:** Our staff or state or federal officials may check the information on the application at any time during the year.

**REPORTING CHANGES:** Households approved for free or reduced-price meals are not required to report changes in income status, household size or when the household is no longer eligible for Food Stamps, TANF, Head Start, Early Head Start or Even Start. This provision does not apply to a household provided with "temporary" approval for meal benefits.

**SPECIAL NEEDS:** If your child is determined by a doctor to have special dietary needs as a result of a disability or other physical condition, please call us.

**FOSTER CHILDREN:** Some foster children may be eligible regardless of your income. If you have foster children living with you and you want to apply for free or reduced-price meals for them, call us.

**CONFIDENTIALITY:** The information you provide will be treated confidentially and will be used only to determine eligibility and verify information.

**NONDISCRIMINATION:** 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 Adjudication and Compliance, 1400 Independence Ave., SW, Washington, D.C. 20250-9410 or call 202-260-1026, 866-632-9992 (toll free) or 202-401-0216 (TDD). USDA is an equal opportunity provider and employer.

If you have any questions or need help filling out an application, please contact us.

**SOLICITUD COMPLETA.** Para que la solicitud se considere completa tiene que tener (1) el nombre de los niños inscritos, (2) la cantidad total y la fuente de los ingresos de la unidad familiar, (3) el nombre de todos los miembros de la unidad familiar, (4) el Número de Seguro Social del miembro adulto de la unidad familiar que firma la solicitud, o una nota que aclare que el miembro no tiene un Número de Seguro Social y (5) la firma de un miembro adulto de la unidad familiar. La unidad familiar que recibe TANF o Estampillas para Comida solo tiene que dar el nombre de los niños, el número de su caso y la firma de un miembro adulto de la unidad familiar.

**VERIFICACIÓN.** Puede ser que nuestro personal o los funcionarios estatales o federales verifiquen la información de la solicitud en cualquier momento durante el año.

**AVISO DE CAMBIOS.** Las unidades familiares aprobadas para recibir comida gratis o a precio reducido no tienen que informar sobre cambios en los ingresos, el número de personas en la unidad familiar o si la unidad familiar ya no llena los requisitos para Estampillas para Comida, TANF, Head Start, Early Head Start o Even Start. Esta disposición no se aplica a las unidades familiares que tienen aprobación "temporal" para recibir beneficios de comidas.

**NIÑO CON NECESIDADES ESPECIALES.** Si un doctor determina que un niño tiene necesidades dietéticas especiales como resultado de una discapacidad u otro padecimiento físico, por favor, llámenos.

**NIÑOS EN HOGARES TEMPORALES.** En algunos casos, los niños en hogares temporales pueden llenar los requisitos sin tomar en cuenta los ingresos de usted. Si hay niños bajo cuidado temporal viviendo con usted y quiere solicitar comidas gratis o a precio reducido para ellos, por favor, comuníquese con nosotros.

**CONFIDENCIALIDAD.** La información que usted nos dé se mantendrá de manera confidencial y se usará solo para determinar elegibilidad y para verificar información.

**DISCRIMINACIÓN.** De acuerdo con la ley federal y con las normas del Departamento de Agricultura de EE. UU., esta institución tiene prohibida la discriminación por motivos de raza, color, origen nacional, sexo, edad o discapacidad.

Para presentar una queja por discriminación, escriba a USDA, Director, Office of Adjudication and Compliance, 1400 Independence Ave., SW, Washington, D.C. 20250-9410 o llame al 202-260-1026 o al 866-632-9992 (gratis) o al 202-401-0216 (TDD). El USDA es un proveedor y empleador que ofrece igualdad de oportunidades para todos.

Si tiene alguna pregunta o necesita ayuda para llenar la solicitud, por favor, comuníquese con nosotros.



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

<b>Part 1. All Household Members</b>				
<b>Name of Enrolled Child(ren):</b>				
<b>Names of all household members</b> (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.			CHECK IF NO INCOME
	<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"/>
<b>Part 2. Benefits:</b> If any member of your household receives SNAP, TANF, or FDPIR, provide the name and case number for the person who receives benefits. <b>If no one receives these benefits, skip to part 4.</b> NAME: _____ CASE NUMBER: _____				
<b>Part 3. (Applies only to parents/guardians with children enrolled in a day care home)</b> If any member of your household receives benefits listed on the enclosed <i>List of Eligible Federal/State Funded Programs (H1660)</i> , provide the name of the program and case number: NAME: _____ CASE NUMBER: _____ Check here if no case number <input type="checkbox"/> <b>If no one receives these benefits, skip to part 4.</b>				
<b>Part 4. Total Household Gross Income—You must tell us how much and how often</b>				
<b>A. Name</b> (List <b>only</b> household members with income)  (Example) Jane Smith	<b>B. Gross income and how often it was received</b>			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly _____	\$150/twice a month _____	\$100/monthly _____	\$200/bi-monthly _____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
<b>Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)</b> An adult household member must sign and date this form. <b>If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.</b> (See Privacy Act Statement on the next page.)  <i>I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.</i>  Sign here: _____ Print name: _____ Date: _____ Address: _____ Phone Number: _____ City: _____ State: _____ Zip Code: _____ Last four digits of Social Security Number: * * * - * * - _____ <input type="checkbox"/> I do not have a Social Security Number				



# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Part 6. Participant's ethnic and racial identities (optional)**

Mark one ethnic identity:	Mark one or more racial identities:	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> Black or African American	

**Part 7. Sharing Information With Other Programs: OPTIONAL**

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- I do elect to allow my household information to be disclosed.
- I do not elect to allow my household information to be disclosed.

**Don't fill out this part. This is for official use only.**

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

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_  
 Categorical Eligibility: \_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free\_\_\_ Reduced\_\_\_ Denied\_\_\_ Tier I\_\_\_ Tier II\_\_\_  
 Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. "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 Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

# What to bring on your first day at Stepping Stones !!!

## **Infants:**

Diapers  
Wipes  
Formula  
Bottles  
Change of clothes

## **Toddlers:**

Diapers  
Wipes  
Crib sized sheet for your toddler's rest mat  
Change of clothes

## **Twos:**

Diapers or Pull-ups  
Wipes  
Crib sized sheet for your two year old's rest mat  
Change of clothes

## **Threes:**

Diapers or Pull-ups  
If potty training:  
Several changes of panties/underware, and clothes  
Wipes  
Crib sized sheet for your three year old's rest mat

## **Fours / Fives:**

Change of Clothes  
Wipes  
Crib sized sheet for your four/five's rest mat

## **Schoolers:**

In the Summertime, sunscreen and a towel

**Please label all of your child's belongings  
with a Sharpie**

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

CODE: \_\_\_\_\_

Child's B-Day: \_\_\_\_\_

\_\_\_\_\_ will feed your infant breast milk provided by you and /or  
(Center Name)  
we will feed the following iron fortified infant formula: \_\_\_\_\_ with iron.

### Infant Feeding Preference

This center participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires centers to follow specific meal patterns according to the age of the infant.

Centers participating in the CACFP are required to offer infant formula to infants who are enrolled for child care. Parents (or guardians) may decline the infant formula offered by the center, and supply the infant's formula.

Parent (or guardian) completes the following table(s) as appropriate:

Please mark your preference (choose all that apply)	Today's Date	Today's Date	Today's Date
	Birth - 3 months	4 - 7 months	8 - 11 months
I will bring expressed breast milk for my infant:	_____	_____	_____
I want the center to provide the Infant formula for my infant	_____	_____	_____
I will bring the infant formula for my infant. It is the following brand: _____	_____	_____	_____

According to CACFP requirements, in order to claim meals for reimbursement, the center must provide infant cereal or other foods when your infant is developmentally ready to accept them.

Please mark your preference (choose all that apply)	Today's Date	Today's Date
	4 - 7 months	8 - 11 months
I want the center to provide the Infant cereal for my infant	_____	_____
I want the center to provide the fruits and vegetables for my infant	_____	_____
I will bring the infant cereal and/or other foods for my infant:	_____	_____

Parent's (or guardian's) signature: \_\_\_\_\_ Date of signature: \_\_\_\_\_

1. This form should be kept on file for each infant enrolled for child care.
2. This form should be kept current and accurate for each infant enrolled for child care until the infant reached one year of age.
3. If the parent declines the formula and the center provides meal and/or snack components, the meal may be claimed for reimbursement.
4. If the parent declines infant meals/snack, meals and snacks my NOT be claimed for reimbursement.