Greater Achievement Child Enrichment Center 1 & 2
Enriching children for the future

14220 Harvard Ave.
Cleveland, Ohio 44128
(216)561-3274 phone
(216) 561-3293 fax
4035 E. 141st Street
Cleveland, Ohio 44128
(216) 785-9982 phone
(216) 785-9814 fax

Registration Form

Children Information

Name _____

Address _____

Telephone _____

Date of Birth _____

Sex _____

List names of people who will pick up your child.

1. _____

2. _____

3. _____

4. _____

Mother

Name _____

Age _____ Marital Status _____

Name of Employer/Training Program/School

_____

Hours and Dates of Work/School _____

Phone Number of Work/School _____

Father

Name _____

Age _____ Marital Status _____

Name of Employer/Training Program/School

_____

Hours and Dates of Work/School _____

Phone Number of Work/School _____

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Getting to know you and your child

Number of children in the family_____

Is the child being enrolled the oldest, youngest, only child, etc._____

Who cared for your child prior to enrollment in this daycare? _____

Has the child attended another daycare? _____

Is there any information we need to know about your child? _____

Has anything important occurred recently, that would affect your child behavior? _____

_____

What would you like the center to do for your child this year?

_____

In the event of an emergency and the parents cannot be reached please contact the following

Name_____ Name_____

Telephone_____ Telephone_____

Relationship_____ Relationship_____

Address_____ Address_____

Ohio Department of Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name	Date of Birth	First Day at Program
Address		
City	State	Zip Code
Parent #1 Name	Parent #1 Phone Number	
Parent #1 Address ☐Same as Child's	City / State / Zip Code	
Parent #1 Email Address (if applicable)	Parent #1 Cell Phone (if applicable)	
Parent #1 Work/School Name (if applicable)	Parent #1 Work/School Phone Number (if applicable)	
Check here if Not Applicable ☐ / Parent #2 Name	Parent #2 Phone Number	
Parent #2 Address ☐Same as Child's	City / State / Zip Code	
Parent #2 Email Address (if applicable)	Parent #2 Cell Phone (if applicable)	
Parent #2 Work/School Name (if applicable)	Parent #2 Work/School Phone Number (if applicable)	
Primary Emergency Contact #1 Name (cannot be parent/guardian)	Check here if Not Applicable ☐ / Optional Emergency Contact #2 Name (cannot be parent/guardian)	
Primary Emergency Contact #1 Phone Number	Optional Emergency Contact #2 Phone Number	
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*	Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*	
My child may be released to this emergency contact ☐ Yes ☐ No	Optional My child may be released to this emergency contact ☐ Yes ☐ No	

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program has permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.

☐ **The program does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures/parent handbook.

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature	Date

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

Ohio Department of Children and Youth

HEALTH CARE PLAN DOCUMENTATION & PERMISSION TO ADMINISTER MEDICATION FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance and update annually and as needed when a child has a special chronic health condition that may require the program to perform a medical procedure or administer medication. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

HEALTH CARE PLAN DOCUMENTATION

Child's Name	Date of Birth

If the child does not have a special chronic health condition or diagnosis check here: ☐
Skip to page 2 to give permission to administer medication/medical food.

Complete a new form or provide separate documentation for each condition that requires different actions to be taken.

☐ **Check here if additional information/documentation is attached from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN).** This documentation may serve as a substitute for page 1.

Special Chronic Health Condition

What are the signs, symptoms, or situations which require staff to take action, perform a medical procedure and/or administer medication or medical food?

What are the activities, foods, conditions, etc. to avoid? ☐ Not Applicable

What are the instructions to care for the child or perform a medical procedure?

If the child's health condition does not improve or side effects to medication appear, trained staff will do one or more of the following:

☐ Call 9-1-1

☐ Call Parent

☐ Other:

Additional Information and/or what is needed if the child care program must be evacuated:

If the special health condition does not require administering medication/medical food: STOP HERE AND SKIP TO PAGE 3

Page 1 is completed to provide instructions for performing a medical procedure.

PERMISSION TO ADMINISTER MEDICATION

Instructions from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) are required for administering:

- Medical foods.
- Prescription medications, including samples.
- Non-prescription medicines containing aspirin.
- Topical preventative products and lotions or non-prescription medications, when the instructions for use exceed or do not match the manufacturer's instructions or are not stored in original container.

Child's Name	Date of Birth	Weight (if needed to determine dosage)

What are the instructions to administer medication or medical food?

☐ **Not Applicable: Instructions are not required if the prescription medication is stored in the original container with prescription label that includes the child's full name, exact dosage, and directions for use.**

What actions are to be taken if the medication or medical food is not available?

Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration ☐ Administer because symptoms are present	Time of Medication/Medical Food Administration ☐ Administer because symptoms are present	Time of Medication/Medical Food Administration ☐ Administer because symptoms are present

SIGNATURE PAGE

Child's Name

PARENT/GUARDIAN

By signing this form I attest that: (check all that apply)

- ☐ I have provided information for care or implementing a medical procedure
- ☐ I have trained staff and have given permission to perform the procedure
- ☐ I have trained staff and have given permission to administer medication to my child

Parent Signature	Date of Signature

LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE REGISTERED NURSE, LICENSED DENTIST

Health Care Professional's signature is only required in this box if their instructions have been provided on this form, prescribed medication does not have a prescription label, or as directed by the manufacturer's instructions.

Physician Signature	Date of Signature

CERTIFIED PROFESSIONAL TRAINER

(A signature from a Certified Professional Trainer is not required if the parent/guardian has provided instructions for care, training, or administering medication)

If a Certified Professional Trainer provided instructions, my signature indicates that:

☐ I have provided instructions for care and/or training for the medical procedure.

☐ I have provided instructions for administering medication.

Certified Professionals Name (please print)	Phone Number
Certified Professionals Signature	Date of Signature

PROGRAM STAFF

Signatures of all individuals who have received instructions for care, have been trained in performing the procedure for this child and/or administering medication. Additional names and signatures can be attached on a separate sheet.

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

DOCUMENTATION OF ADMINISTRATION OF MEDICATION OR MEDICAL FOOD			
Child's Name			Name of Medication/Medical Food
Date	**Time**	**Dosage**	**Signature of person administering medication/medical food**

Reset Form

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

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

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

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

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

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

What causes your child to feel angry or frustrated?

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

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

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

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

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

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

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

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

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

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.
What might you and/or your child be anxious about as he/she starts in this program?
What are you and/or your child excited about as he/she starts in this program?
What are your expectations of this program?
What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date

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Permissions & Agreement

Field Trips

I hereby give permission for the staff to take my child on field trips with the understanding that I will be notified in advance whenever these field trips will involve any form of transportation (other than walking). Furthermore, I understand that the center accepts full responsibility for my child's safety.

Parent/Guardian Signature_____

Date_____

Photographs & Recordings

I hereby give permission for the staff to use photographs and/or recordings of my child for noncommercial educational and publicity purposes.

Parent/Guardian Signature_____

Date_____

Tuition & Participation

I hereby agree to pay whatever fees have been set for me, when due and to participate in the program as much as possible. I will follow the rules and procedures of the program that have been presented to me.

Parent/Guardian Signature_____

Date_____

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Child Care Center Fee Agreement

I, _____, am responsible to pay the aforementioned

Caretaker Parent

Provider a fee of $_____ for my child, _____ on

Child Name

a _____ basis. This fee is payable no later than the 5th day of the month.

Monthly/Weekly

I understand that my child my child may not start care in a new month without a payment of the previous month. In addition to the monthly child care copayment, I may be required to pay fees which aren't the responsibility of the County Agency upon satisfactory arrangements with the child care provider. These types of fees include, but are not limited to late fees, activity fees, transportation fees, fees charged for absentee days which exceed those reimbursed by the County Agency and fees charged by the provider for child care services which exceed the hours and days authorized. I further understand according to Rule 5101:2-16-35(K)(1), ineligible for child care benefits shall continue as long as delinquent copayments are owed to the child care provider, unless satisfactory arrangements are made to pay delinquent copayments. Arrangements to pay delinquent copayments must be satisfactory to both the caretaker parent and the provider. By signing this document, I agree to abide by these terms.

Caretaker Parent_____

Date_____

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Welcome to Greater Achievement Child Enrichment Center 1 & 2

Please bring the following items for your child/ren to be left at the center.

1. A box of Pampers (infant/toddler class)
2. A box of Kleenex (all classes, except school age)
3. Baby wipes (all classes, except school age)
4. A small sheet/ blanket and a small pillow (toddlers/preschool)
5. Sleeping sack, or swaddle(with Velcro straps) (infants)
6. A complete change of clothes (all classes, except school age)
7. A plastic bib with pocket (infants/ toddlers)

Please make certain all items including change of clothes are properly labeled with your child name or initials.

If you have any questions please feel free to talk to, or call the center and ask.

Thank you

Mrs. Toni Sparks

Center Director

Ohio Department of Children and Youth

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s) Greater Achieve. 1 & 2, Jamison, Nature walks Library on 13st in Harvard & Shaker

Date of Permission *(valid for one year)*

Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*

During this trip children will have access to water that is 18 inches or more in depth.
☐ Yes ☐ No

Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☐ No
(if yes, a swimming permission slip is required)

Child's Information

Child's Name

My child is
☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"

Signature

I grant permission for my child to participate in the routine trips described above.

Parent's Signature	Date

Reset Form

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2026-2027

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

CENTER NAME

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation)
1.			☐
2.			☐
3.			☐
4.			☐

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.

Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)

CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _

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

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

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

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

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

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

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

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

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

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

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion:
Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

☐ **FREE,** based on ☐ Food Assistance/OWF Case No.
☐ Household size and income
☐ Foster Child

☐ **REDUCED-PRICE,** based on Household size and income

Total Household Size: _____

Total Household Income: $_____

Per: ☐ week ☐ every two weeks ☐ twice per month ☐ month ☐ year

☐ **PAID,** based on ☐ Income too high
☐ Incomplete
☐ Invalid case number or information

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

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

HOUSEHOLD LETTER - Dear Parent or Guardian

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

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

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

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

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

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

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

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

a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

b) Check the box for any person listed as a household member (including children) that has no income.

c) For each household member, list each type of income received during the last month and list how often the moneywas received.

1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, regarding deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
2. List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

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

a) * All applications must have the signature of an adult household member.

b) * The adult signing the application must also date theform.

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

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

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

NON-DISCRIMINATION STATEMENT: In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20260-9410; **Fax:** (202) 690-7442; or **Email:** program.intake@usda.gov

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REDUCED-PRICE INCOME ELIGIBILITY GUIDELINES

Guidelines to be effective from July 1, 2026 through June 30, 2027.

Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price mealbenefits.

Number of Members	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	$29,526	2,461	1,231	1,136	568
2	$40,034	3,337	1,669	1,540	770
3	$50,542	4,212	2,106	1,944	972
4	$61,050	5,088	2,544	2,349	1,175
5	$71,558	5,964	2,982	2,753	1,377
6	$82,066	6,839	3,420	3,157	1,579
7	$92,574	7,715	3,858	3,561	1,781
8	$103,082	8,591	4,296	3,965	1,983
Each Additional Member Add	$10,508	876	438	405	203

Ohio Department of Education and Workforce - Office of Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

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

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

Instructions to Complete

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

CENTER NAME		
CHILD'S NAME (please print)	AGE	BIRTHDATE month / day / year

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

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

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

SIGNATURE OF PARENT/GUARDIAN	DATE	DAY PHONE NUMBER
MAILING ADDRESS STREET /APT.	CITY	ZIP CODE
PARENT BIRTHDATE month / day / year	PARENT EMAIL	

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Revised 8/2025

Parent Interview Guide

Quality Childcare Begins With Communication!

Hi Parents! Thank you for inquiring about our childcare program. Please complete this guide throughly and honestly. We use this guide as a way to help us improve our services and build a quality relationship with you. We promise we will not sale or rent your information. We value you and appreciate your time. Enrolling your child with us would be our pleasure!

PARENT INFORMATION:

Date_____

Name_____ Address_____

First Last

Cell Number:_____ Email Address _____

Facebook Handle_____

Age____ DOB_____ Place Of Employment_____

PLEASE CIRCLE YOUR CURRENT HOBBIES:

Reading (Best Book)_____ Writing

Sports (What Type)_____ Dance

Church (Where Do You Attend)_____

Work Other_____

Shopping (Where Do You Shop)_____

Dining Out (Where Do You Dine) _____

YOUR CHILD'S INFORMATION:

Name_____ Age_____ DOB_____

What Challenges Are You Having With Finding Quality Childcare That BEST fits you? Check All That Pertains To You.

Affordability__Quality__ Location__Hours__Availability__Other (Please Explain)_____

YOUR PARENT EXPECTATIONS :

How did you find out about our childcare program?

_____

Describe the best childcare experience you want for your child?

_____

_____

Parent Interview Guide

Please Complete This Section After Touring With Us

YOUR CHILDCARE SEARCH DETAILS:

Describe what you found helpful during your tour with us?

_____

_____

What impressed you the most about our childcare program?

_____

_____

How else can we be of help to you and your child?

_____

_____

What else can we do to further assist you?

_____

_____

FOR RESEARCH PURPOSES:

How did you find out about us?_____

Did You Go On To Our Company Website? _____

Did You Google Us?_____Did You Review Our Facebook Timeline?_____

Did You Review Our Youtube Page?_____

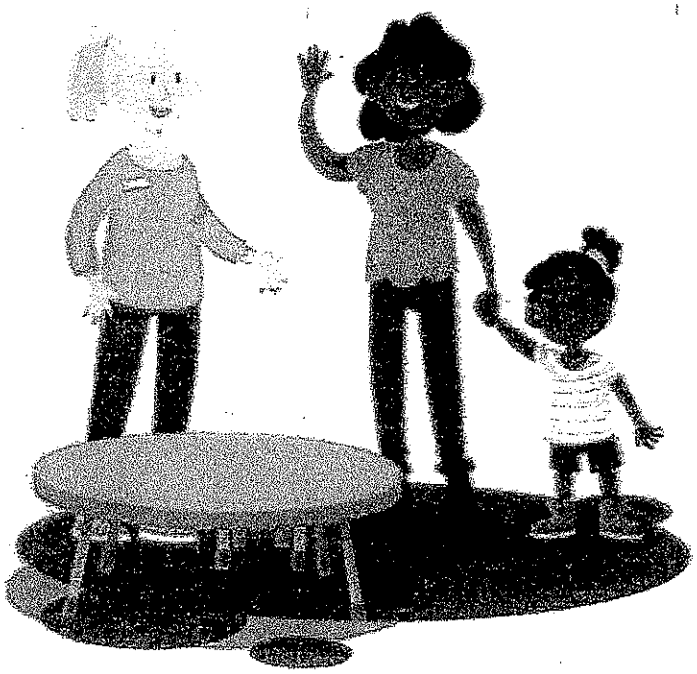
In The Last Week, How Many Locations Have You Toured Besides Us? _____

Thank you so much for your time! We would love to offer you our special enrollment deals. Please return to the administrator. Thanks!

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.



Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

Child Care Resources
203 Hull St Suit A
Richmond, VA 23224
804-339-2022

CACFP Program Specialist
25 S Front St
Columbus, OH 43215
877-644-6388

Learn more about CACFP at USDA's website:

https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

¡Buena nutrición hoy significa un mañana más saludable!

Construyendo para el Futuro con CACFP

Esta guardería infantil recibe ayuda del Child and Adult Care Food Program para servir comidas nutritivas a sus niños.

Comidas servidas aquí deben de seguir los requisitos nutricionales establecidos por USDA.

¿Preguntas? ¿Inquietudes?

Child Care Resources
203 Hull St Suit A
Richmond, VA 23224
804-339-2022

CACFP Program Specialist
25 S Front St
Columbus, OH 43215
877-644-6388

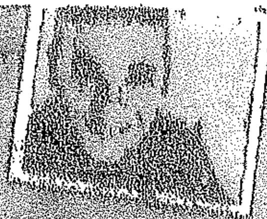
Aprenda más información sobre CACFP en el sitio web del USDA: https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
Noviembre 2019

Reach for the Stars!

step up to quality

Ohio's Three Quality Rating & Improvement System



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Early Experiences Last a Lifetime

step up to quality

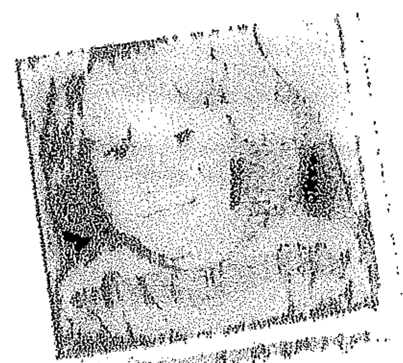
1-STAR Programs

- Administrators and teachers show a commitment to increasing professional knowledge and skills by receiving 20 hours of specialized training every two years.
- Teachers become familiar with the *Ohio Early Learning and Development Standards* to support children's development and learning.
- Programs begin building relationships with families and communities which support children's progress and well-being.

step up to quality

2-STAR Programs

- The program demonstrates commitment to quality by hiring teachers with higher education qualifications than 1-Star programs.
- Teachers use the *Ohio Early Learning and Development Standards* to support children's learning.
- The program engages in a continuous improvement process by completing a self-assessment.
- Administrators and teachers are committed to increasing professional knowledge and skills by receiving 20 hours of specialized training every two years.



step up to quality

3-STAR Programs

- The program demonstrates commitment to quality by hiring teachers with higher education qualifications than 2-Star programs.
- Administrators and teachers are committed to increasing professional knowledge and skills by receiving 20 hours of specialized training every two years.
- Staff conducts self-assessments and uses the results to identify strengths and develop action plans to improve classroom practices.
- The program expands the continuous improvement process by developing an action plan with goals for overall program development.
- Children's individual needs are met and child progress is monitored and shared regularly with families.
- Families and staff work together to develop goals for children.

step up to quality

4 & 5-STAR Programs

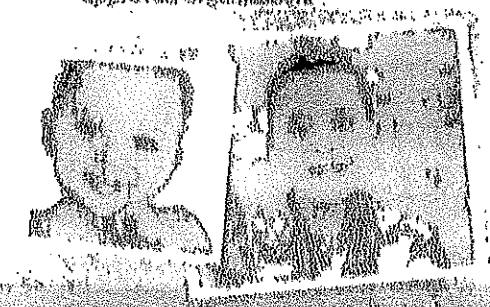
Achieving a 4- or 5-Star Rating means that a program has demonstrated a level of quality that meets all the requirements of a 3-Star Rating and is eligible to gain the additional points needed to achieve a higher Star Rating.

Programs have the flexibility to earn points in the areas that best support their values, goals and structure. Here are some examples of increased quality at the 4- and 5-Star level:

- Administrators and teachers hold higher education qualifications than 3-Star programs.
- Administrators and teachers demonstrate the value of ongoing professional development by completing more than the required 20 hours of specialized training every two years.
- The needs, interests and abilities of children are the basis for developing experiences and activities.
- Teachers use child assessment results to plan activities and make changes to their classroom to best support learning and development goals for each child.

step up to quality

- Program has an active and organized parent volunteer group.
- Families and community partners' input is used to inform the program's continuous improvement process.
- Programs work collaboratively with families to share assessment results, create goals for children, and develop plans to support children as they transition to a new classroom or educational setting.
- Programs work with other organizations or businesses within the community to support children and their families.
- Lower Teacher/Child Ratios.
- Program is accredited by an approved organization.



BOLD Beginnings

Ohio Department of Education
Ohio Department of Job and Family Services

John R. Kasich, Governor
State of Ohio

Paolo DeMaria, Superintendent of Public Instruction
Ohio Department of Education

Cynthia C. Dungey, Director
Ohio Department of Job and Family Services

These institutions are equal opportunity providers and employers.

JFS 01564 (Rev. 9/2017)

WIC is the nation's most successful and cost-effective public health nutrition program. We provide wholesome food, nutrition education, and community support for income-eligible women who are pregnant or postpartum, infants, and children up to five years old.

FOOD. EDUCATION. SUPPORT. YOU GOT THIS.

We give moms the resources, knowledge, and tools they need to be the moms they want to be.

HEALTHY FOOD

Through WIC, moms get monthly benefits to buy healthy foods, such as:

Foods with calcium for strong bones and teeth:

- Milk.
- Cheese.
- Soy beverages.
- Yogurt.

Foods with protein for strong muscles and healthy skin:

- Dried or canned beans, peas, lentils.
- Eggs.
- Canned tuna or salmon.
- Peanut butter.
- Tofu.

Grains with iron for energy, and folic acid for healthy growth:

- Cereal.
- Brown rice.
- Soft corn or whole wheat tortillas.
- Whole grain bread.
- Whole wheat pasta.

Iron-fortified foods for infants who need it:

- Baby foods.
- Infant formula.
- Infant cereal.

Fruits and vegetables to keep your heart and weight healthy:

- Fresh, frozen, or canned fruits and vegetables.
- 100% fruit or vegetable juice.

NUTRITION EDUCATION

We support and educate moms to help them breastfeed successfully. We offer guidance on how to shop for healthy food, how to prepare it, and how to encourage children to eat it. We provide access to information, including:

- Prenatal nutrition.
- Breastfeeding tips.
- Eating tips for your child.
- Parenting tips.
- Healthy recipes.

A COMMUNITY OF SUPPORT

We're a network built for moms. We connect them, we educate them, and we learn from them. Our community consists of:

- Health providers.
- Lactation specialists.
- Peer helpers.

REFERRALS

We can introduce moms to resources outside of WIC, including:

- Healthcare providers such as pediatricians, OB/GYNs, and dentists.
- Immunization services.
- Substance use disorder counselors.
- Domestic abuse counseling.
- Social services.

BREASTFEEDING SUPPORT

We offer guidance for nursing moms:

- Advice on a range of breastfeeding issues, including positioning, latch, milk production, and returning to work.
- Nursing aids such as breast pumps.

ALL CAREGIVERS ARE WELCOME.

We talk a lot about moms. But we offer support to anyone—working or not—who cares for a child, including:

- Moms.
- Dads.
- Grandparents.
- Foster parents.
- Step-parents.
- Guardians.

WE'RE HERE FOR YOU.

We're here for more moms and caregivers than you might think—in fact, we serve over half of all infants born in the U.S. To get WIC assistance, participants:

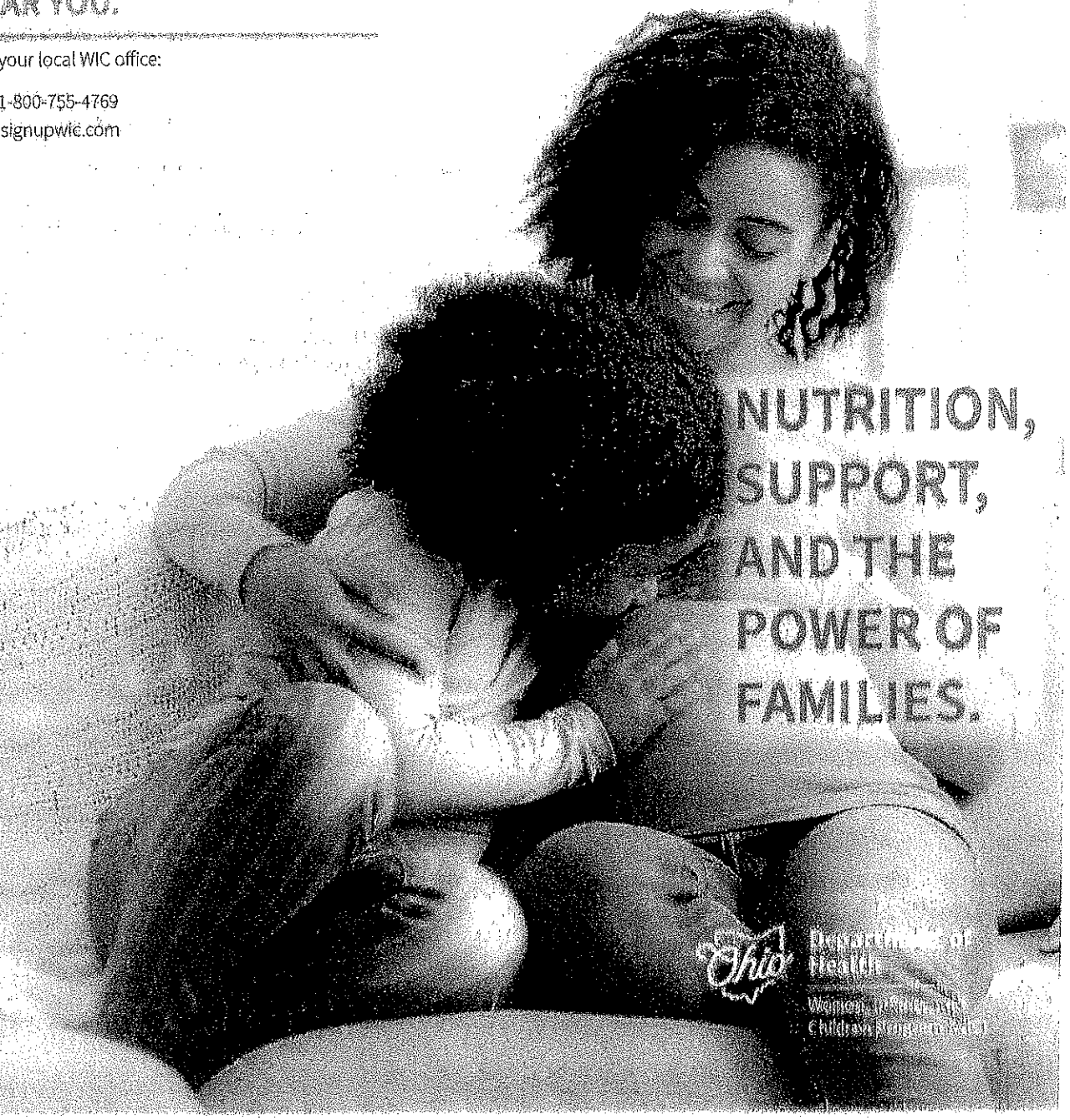
- Must be pregnant or have infants or children under 5 years old.
- May be in need of income assistance.
- Can be receiving other benefits like foster care, medical assistance, or SNAP.

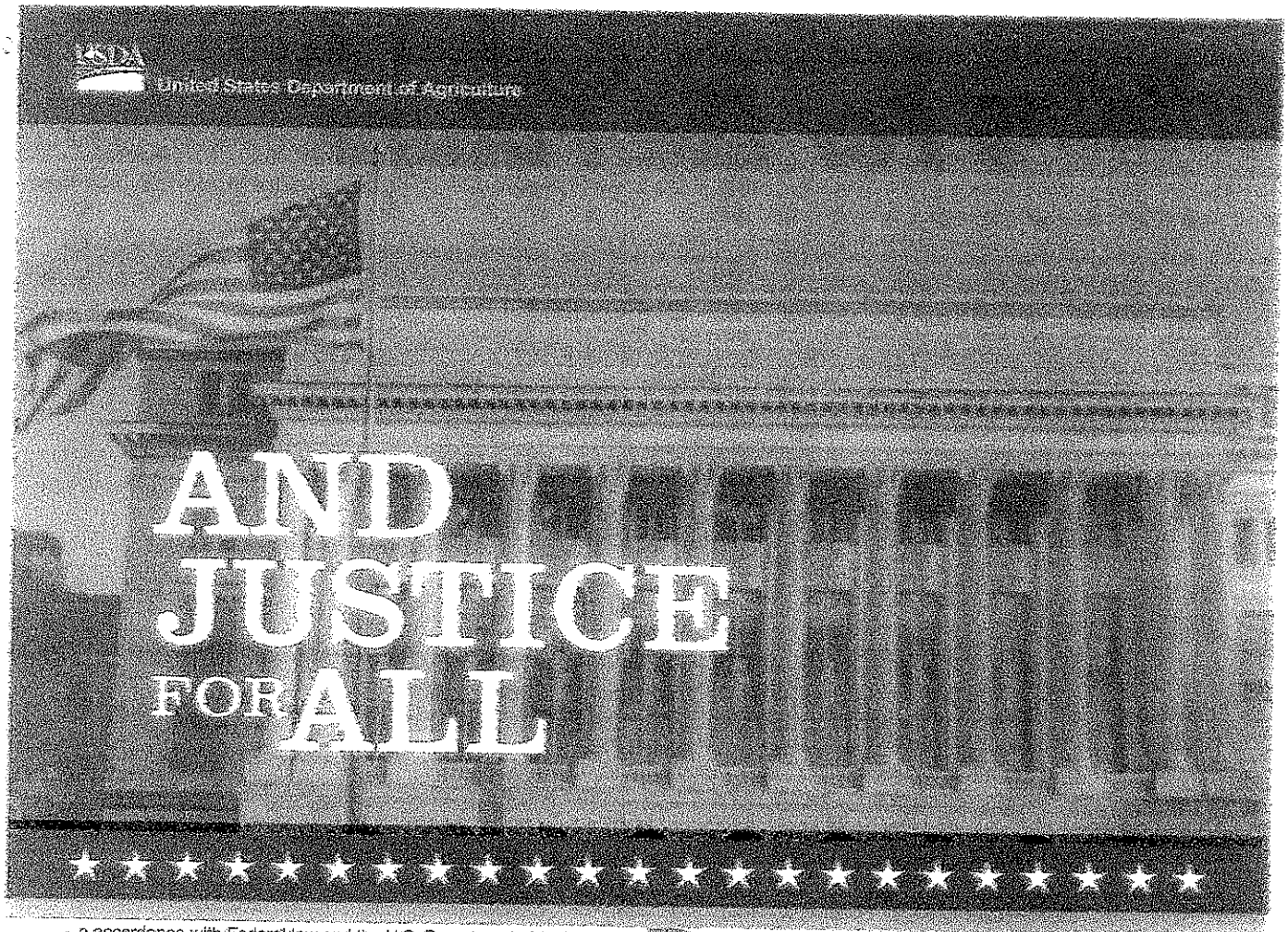
HEA 8332

FIND WIC NEAR YOU.

Find your local WIC office:

Call: 1-800-755-4769
Visit: signupwic.com





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

email:
program.intake@usda.gov

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La información del programa puede estar disponible en idiomas distintos al inglés. Las personas con discapacidades que requieran medios alternativos de comunicación para obtener información del programa (p. ej., braille, letra grande, cintas de audio y lenguaje de señas americano) deben comunicarse con la agencia estatal o local responsable que administra el programa o comunicarse con el USDA a través del Servicio de Retransmisión de Telecomunicaciones al 711 (voz y TTY).

Para presentar una queja por discriminación en el programa, el reclamante debe completar el formulario AD-3027, el formulario de queja por discriminación en el programa del USDA, que se puede obtener en línea, en https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf, desde cualquier oficina del USDA, llamando al (866) 632- 9992 o escribiendo una carta dirigida al USDA. La carta debe tener el nombre, la dirección, el teléfono del reclamante y una descripción escrita de la supuesta acción discriminatoria con suficiente detalle para informar al subsecretario de derechos civiles (ASCR) sobre la naturaleza y la fecha de una supuesta violación de los derechos civiles. El formulario AD-3027 o la carta completos deben enviarse al USDA por:

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

correo electrónico:
program.intake@usda.gov

Esta institución ofrece igualdad de oportunidades.

Building For the Future

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

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

Meals

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five components)
Milk Fruit OR Vegetable Grains or Bread* *Meat/Meat Alternate may replace entire grain up to 3x/week	Milk Meat or meat alternate Grains or bread Vegetable AND Fruit or Second Vegetable (If serving two vegetables they must be different foods)	Milk Meat or meat alternate Grains or bread Fruit Vegetable

Participating Facilities

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

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

Eligibility

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

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

Contact Information

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

Sponsoring Organization/Center

Child Care Resources, Inc.
5 East 2nd Street
Richmond, VA 23224
Toll Free: 1-855-427-2888

Ohio Department of Education and Workforce

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

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2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

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Revised 08/2025

Reset Form

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below*):

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

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

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above.	
If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	**Signature of Parent**
☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	Date