



Student Name: _____ Date: _____

Child Enrollment Checklist

DIRECTOR RESPONSIBILITY		Status' (if needed)
	Register Record	
	DOH Health Certificate	
	Travel Authorization	
	Authorization for Child's Emergency medical Treatment	
	IES Form	
	Subsidy Voucher? (Attach)	
	Family Handbook	
	Parent EMAIL ADDRESS	
ADMINISTRATION		
	Procure with Immunization Dates	
	CACFP Master Enrollment List	
	Parent Engagement App	
	Updated Classroom Roster	

Approvals: (Enrollment / Systems Updates)

Director Name: _____

Date: _____

Executive Administrator: _____

Date: _____

Parent/Guardian Email Address: _____



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: ☐ Male ☐ Female
Last First M.I.
Date of Birth: _____ Home #: _____ Language Spoken At Home _____
Home Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____
Home Address: _____
Number Street Apt. # State ZIP
Business Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____
Home Address: _____
Number Street Apt. # State ZIP
Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____
Home Address: _____
Number Street Apt. # State ZIP
Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):

_____ Relationship to child: _____
Last First M.I.
Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

_____ Last First M.I.
_____ Last First M.I.
_____ Last First M.I.

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____
Date of Withdrawal: _____ **Reason:** _____



DISTRICT OF COLUMBIA
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***DIVISION OF EARLY LEARNING
Licensing and Compliance Unit***

**AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
(Update Annually)**

If my child _____, born on ____/____/____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____
or:

Physician: _____ M.D. Telephone No: _____

Address: _____ (Area Code)

I give permission to _____, located at
Name of Facility or Caregiver _____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ☐ DC ☐ MD ☐ VA

Child's known Allergies or Physical Conditions: _____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____
Home Business Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year

Place in child's folder/record.



DISTRICT OF COLUMBIA
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TRAVEL AND ACTIVITY AUTHORIZATION

- ☐ Special one time permission for this activity only ☐ Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian
_____ give my permission
Name of Child
_____ for my child to
participate in the following activities:

Trips in the van/automobile (facility or parent - owned)

Explain planned activity - where and when

Field trips away from the facility

Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devices and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

- ☐ I will allow my child to play outside the fenced area; or
☐ I will not allow my child to play outside the fenced area.

This authorization is valid from ____/____/____ to ____/____/____

Parent/Guardian Signature

Date Signed

PLEASE KEEP A COPY IN THE CHILD'S FILE.



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

Medication Administration Authorization Form

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1; "A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5, "A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log."

Part I: To be completed by the parent/guardian and child's physician:

I do hereby give permission to _____ to administer the following
Name of Facility
prescribed medication to my child _____ born on _____.

Name of Medication	Time/Frequency	Dosage	Effective Dates	
			From:	To:

Signature of Physician

Date

Signature of Parent/Guardian

Date

Part II: To be completed by the center director or staff administering medication who has current medication administration certificate:

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE PLACE A COPY IN THE CHILD'S FILE.

Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at <https://dchealthlink.com>. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:		Child First Name:		Date of Birth:	
School or Child Care Facility Name:			Gender: ☐ Male ☐ Female ☐ Non-Binary		
Home Address:		Apt:	City:	State:	ZIP:
Ethnicity: (check all that apply) ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer					
Race: (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer					
Parent/Guardian Name:			Parent/Guardian Phone:		
Emergency Contact Name:			Emergency Contact Phone:		
Insurance Type: ☐ Medicaid ☐ Private ☐ None			Insurance Name/ID #:		
Has the child seen a dentist/dental provider within the last year? ☐ Yes ☐ No					

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ Date: _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	BP: ☐ NML ☐ ABNL	Weight: ☐ Lf ☐ KG	Height: ☐ IN ☐ CM	BMI:	BMI Percentile:
Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ☐ Corrected ☐ Uncorrected ☐ Wears glasses ☐ Referred ☐ Not tested					
Hearing Screening: (check all that apply) ☐ Pass ☐ Fail ☐ Not tested ☐ Uses Device ☐ Referred					

Does the child have any of the following health concerns? (check all that apply and provide details below)

- | | | |
|---|--|---|
| ☐ Asthma | ☐ Failure to thrive | ☐ Sickle cell |
| ☐ Autism | ☐ Heart failure | ☐ Long term COVID-19 symptoms |
| ☐ Behavioral | ☐ Kidney failure | ☐ Significant food/medication/environmental allergies that may require emergency medical care. Details provided below. |
| ☐ Cancer | ☐ Language/Speech | ☐ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. Details provided below. |
| ☐ Cerebral palsy | ☐ Obesity | ☐ Significant health history, condition, communicable illness, or restrictions. Details provided below. |
| ☐ Developmental | ☐ Scoliosis | ☐ Other: _____ |
| ☐ Diabetes | ☐ Seizures | |

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB? ☐ High → complete skin test and/or Quantiferon test ☐ Low	Skin Test Date:		Quantiferon Test Date:	
	Skin Test Results: ☐ Negative ☐ Positive, CXR Negative ☐ Positive, CXR Positive ☐ Positive, Treated			
	Quantiferon Results: ☐ Negative ☐ Positive ☐ Positive, Treated			
Additional notes on TB test: _____				

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS Every child must have 2 lead tests by age 2	1st Test Date:	1st Result: ☐ Normal ☐ Abnormal, Developmental Screening Date:	1st Serum/Finger Stick Lead Level:
	2nd Test Date:	2nd Result: ☐ Normal ☐ Abnormal, Developmental Screening Date:	2nd Serum/Finger Stick Lead Level:
HGB/HCT Test Date:		HGB/HCT Result:	

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:		Child First Name:				Date of Birth:	
Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by: _____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Coronavirus (COVID) (Recommended)	1	2					
Other	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)

I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

- | | | | | | | |
|-------------------------------------|----------------------------------|------------------------------------|---------------------------------------|-------------------------------|--|----------------------------------|
| ☐ Diphtheria | ☐ Tetanus | ☐ Pertussis | ☐ Hib | ☐ HepB | ☐ Polio | ☐ Measles |
| ☐ Mumps | ☐ Rubella | ☐ Varicella | ☐ Pneumococcal | ☐ HepA | ☐ Meningococcal | ☐ HPV |

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until: _____ (date)

Alternative Proof of Immunity (if applicable)

I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

- | | | | | | | |
|-------------------------------------|----------------------------------|------------------------------------|---------------------------------------|-------------------------------|--|----------------------------------|
| ☐ Diphtheria | ☐ Tetanus | ☐ Pertussis | ☐ Hib | ☐ HepB | ☐ Polio | ☐ Measles |
| ☐ Mumps | ☐ Rubella | ☐ Varicella | ☐ Pneumococcal | ☐ HepA | ☐ Meningococcal | ☐ HPV |

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is in **satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports**. ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp

Provider Name:

Provider Phone:

Provider Signature:

Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:

Signature:

Date:

Health Suite Personnel Name:

Signature:

Date:

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (MMDDYYYY)

--	--	--	--	--	--	--	--

Home Zip Code

--	--	--	--	--	--

School
Grade

Day-

care

PreK3

PreK4

K

1

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12

Adult
Ed.

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Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No		
Q1 Does the patient have at least one tooth with apparent cavitation (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐		
Q2 Does the patient have at least one treated carious tooth ? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐		
Q3 Does the patient have at least one permanent molar tooth with a partially or fully retained sealant ?	☐	☐		
Q4 Does the patient have untreated caries or other oral health problems requiring care before his/her routine check-up ? (Early care need)	☐	☐		
Q5 Does the patient have pain, abscess, or swelling ? (Urgent care need)	☐	☐		
Q6 How many primary teeth in the patient's mouth are affected by caries that are either untreated or treated with fillings/crowns ?	Total Number <table border="1"> <tr> <td></td><td></td> </tr> </table>			
Q7 How many permanent teeth in the patient's mouth are affected by caries that are either untreated, treated with fillings/crowns, or extracted due to caries ?	Total Number <table border="1"> <tr> <td></td><td></td> </tr> </table>			
Q8 What type of dental insurance does the patient have?	Medicaid ☐	Private Insurance ☐		
	Other ☐	None ☐		

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

Medication and Medical Procedure Treatment Plan

Use this form to detail your student's medication and/or medical procedure plan to be administered at their school and return it to the Health Suite Personnel. The Health Suite Personnel will contact you to arrange medication/medical supply drop-off. For multiple needs, complete multiple sheets.

Part 1: Student and Parent/Caretaker Information | To be completed by student's parent/caretaker.

Student First Name:	Student Last Name:	Grade:
School Facility Name:		Student DOB:
Parent First Name:	Parent Last Name:	
Parent Email:	Parent Phone:	

I hereby request and authorize Health Suite Personnel to administer prescribed medication/treatment as directed by the licensed health care providers to the student named in Part I. I understand that:

- I am responsible for bringing the necessary medications/medical supplies to school for the Health Suite Personnel.
- All medication/medical supplies will be stored in a secured area of the school. Health Suite Personnel will not assume any responsibility for possible loss of student medication/medical supplies.
- Within one week of the expiration of the medication/medical supplies and/or within one week of the end of the school year, I must collect what is unused or it will be destroyed.
- The School or Health Suite Personnel will not assume any responsibility for unauthorized medication/treatments that the student gives to himself/herself.
- If any changes occur in my student's health or treatment plan, I will immediately notify the school and health suite personnel annually as required by DC Official Code § 38-651.03.
- Treatment plans and medication plans must be updated annually and when there is any change in the student's health or treatment requirements.
- I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts of omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Parent/Caretaker Signature: _____ **Date:** _____

Part 2a: Student's Medication Plan | To be completed by licensed health care provider.

Diagnosis:	End date for school administration of this medication:
This medication is: ☐ New; the first dose was given at home on date and time: _____ ☐ Renewal ☐ Change	
Is this a standing order? ☐ Yes, epinephrine auto injector 0.15 mg: <i>refer to anaphylaxis plan</i> ☐ Yes, other: _____ ☐ Yes, epinephrine auto injector 0.3 mg: <i>refer to anaphylaxis plan</i> ☐ No ☐ Yes, albuterol sulfate 90 mcg/inh: <i>refer to asthma action plan</i>	

Name and strength of medication:	Dose/route:
---	--------------------

Time and Frequency at School (e.g. 10am and 2pm every day; as needed if standing order)

If a reaction can be expected, please describe:

Additional instructions or emergency procedures:

Part 2b: Student's Medical Procedure Treatment Plan | To be completed by licensed health care provider.

Diagnosis:	This procedure is: ☐ New ☐ Renewal ☐ Change
Treatment:	
When should treatment be administered at school? (e.g. 10am and 2pm every day)	
End date for school administration of this treatment:	
Additional instructions or emergency procedures:	

Has the student's Universal Health Certificate form been updated to reflect new health concerns? ☐ Yes ☐ No

Licensed Health Care Provider Office Stamp

Provider Name:

Provider Phone:

Provider Signature:

Date:

OFFICE USE ONLY | Medication and/or treatment plan received by Health Suite Personnel.

Name:	Signature:	Date:
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Emergent Preparatory Academy

4415 South Capitol Street, SW

Washington, DC 20032

(202) 399 3111

www.emergentprepacademy.com



Dear Parent or Guardian:

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's center/early care and learning center/ECE center! Please fill out the *Enrollment Form/Income Eligibility Statement*. 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 childcare center.

Instructions

Here are instructions to help you complete the *Enrollment Form/Income Eligibility Statement*. 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 out all of the requested information. When you are finished, please return the form to your child care provider.

Part 1: If more than one child in your household is enrolled at this center, you only need to complete **one (1)** form. Please provide all of the information requested in Part 1, including the full name (as it appears on other records) of each child in your household who is enrolled at this center and each enrolled child's date of birth. If the child is in school and attends before and/or after care at this center for most of the year, circle "YES" in the box for "Before & After Care." Circle the day(s) when each child usually attends the center and write each child's usual arrival and departure time. Then, circle which meal(s) each child usually receives from the center. In addition, even if you do not complete Part 2, 3, 4 or 5, you must still print and sign your name in Part 6 and provide your home address and telephone number.

Part 2: If someone in your household receives benefits from the Supplemental Nutrition Assistance Program (SNAP - formerly called Food Stamps) or from Temporary Assistance to Needy Families (TANF), complete Part 2. Write the recipient's name, circle the type of benefit received, and provide the case number. You may circle both SNAP and TANF if the person receives both benefits. Additionally, you must complete Part 6 on the front of the form. You do **not** need to provide the last four digits of your social security number.

Part 3: If your child(ren) enrolled at this center participate(s) in the Head Start/Early Head Start program, complete Part 3. Write the name of each participating child in this section. In addition, you must complete Part 6 on the front of the form. You do **not** need to provide the last four digits of your social security number.

Part 4: If you are completing this form for a foster child who is the legal responsibility of a welfare agency or court, write the name(s) of the foster child(ren) in Part 4, then complete Part 6 on the front of the form. You do **not** need to provide the last four digits of your social security number if applying for foster child(ren) only. Do **not** complete this section if you care for a child under an informal caregiver arrangement or permanent guardianship agreement made outside of a child welfare agency or court. You may include foster children on the same form with non-foster children living in your household. Please read the form for additional instructions.

Part 5: Report current income for all household members. Skip this step if you completed Part 2 or Part 3. If the information above is not reported, the Enrollment Form/Income Eligibility Statement must contain the following information in Part 5: the names of **all** household members (including children enrolled at this center), the total gross income (before taxes) currently received by each household member, the frequency the amount is received, and the signature of an adult household member, and the date the form was completed. Do not include SNAP, TANF, WIC, student financial aid, or money you receive for a foster child as income. In addition, the **primary wage earner or household member who signs the form must provide the last four (4) digits of his/her social security number**. If there is no Social Security number, mark the *Check if no SSN* box.

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.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). Part 5 of this form must include everyone in your household.

You must report the total gross income (before taxes or deductions), listed by source, that each member of your household received during the last month. If you usually receive overtime pay, include it. If your hours or wages were recently reduced, report your current income. For each income amount reported, specify how often that income was received – weekly, every two weeks (biweekly), twice a month (semimonthly), or once a month (monthly). If last month's income does not accurately reflect your circumstances, you may provide your usual income (with frequency) or a projection of your current annual income (specify "annual" for the frequency). You may use last year's income as a basis for making the projection if no significant changes have occurred. If so, please specify "annual" for the frequency.

If a member of your household serves in the military, you do not need to report money received as part of the Military Housing Privatization Initiative, Family Subsistence Supplemental Allowance, Combat Pay, or Deployment Extension Incentive Pay (DEIP). If a household member is currently deployed, report only the portion of the deployed service member's income made available to them or the household. You must include all other income and allowances when reporting gross income.

If your household's total gross income is equal to or less than the amount indicated for your household's size on the chart below, the center receives a higher level of federal reimbursement. Once this form is completed, the eligibility determination will be valid for 12 months. However, you should notify us if you or any other household member becomes unemployed and experiences loss of income. This period of unemployment may result in your household's income qualifying for a different eligibility category.

Part 6: 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.

All meals served to children under the Child and Adult Care Food Program are provided free of charge regardless of race, color, national origin, sex, age, and disability. The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, income derived all or in part from any public assistance programs, or protected genetic information in employment or any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete a USDA Program Discrimination Complaint Form, found online at http://ascr.usda.gov/complaint_file_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410, by fax at (202) 690-7442, or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8330 or (800) 845-6136 (Spanish). If you require the information in an alternative format (Braille, large print, audiotape, etc.), contact the USDA's TARGET Center at (202) 720-2600 (Voice or TDD). USDA is an equal opportunity provider and employer.

In conjunction, the District of Columbia Human Rights Act, approved December 13, 1977 (DC Law 2-38; DC Official Code §2-1402.11(2006), as amended) prohibits discrimination on the basis of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation of any individual. Additional protected traits can be found at <https://ohr.dc.gov/protectedtraits>. To file a complaint alleging discrimination on one of these bases, please contact the District of Columbia's Office of Human Rights at (202) 727-4559 or <https://ohr.dc.gov/service/file-complaint>. If you require information about this program, activity, or facility in a language other than English, contact the District of Columbia Office of Human Right's Language Access Program at (202) 727-4559.

Thank you for your cooperation.

Monica J. Hall
Signature of Authorized Institution Representative

FEDERAL INCOME ELIGIBILITY GUIDELINES					
Effective from July 1, 2021 to June 30, 2022					
Persons in Family (Household Size)	Income Frequency (How Often You Are Paid)				
	Annually	Monthly	Twice per Month	Bi-Weekly (every 2 weeks)	Weekly



The Child and Adult Care Food Program Enrollment Form / Income Eligibility Statement for Children

CENTER NAME: Emergent Preparatory AcademyFISCAL YEAR: 2025**PART 1 – ENROLLMENT INFORMATION**

You must complete ALL five columns of Part 1.

Name(s) of Enrolled Child(ren)	Date of Birth	Before & After Care	Circle Normal Days of Care / Print Normal Hours of Care	Circle the Meals the Child Normally Receives while in Care
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours 7:00 to 6:00	Breakfast A.M. Snack Lunch P.M. Snack Supper
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours 7:00 to 6:00	Breakfast A.M. Snack Lunch P.M. Snack Supper
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours 7:00 to 6:00	Breakfast A.M. Snack Lunch P.M. Snack Supper

INCOME ELIGIBILITY INFORMATION

Please check all that apply and then fill out the parts specified.

- ☐ A member of my household receives SNAP (formerly Food Stamps) and/or TANF benefits. → Please complete Part 2 and Part 6.
☐ One or more of my children participates in Head Start / Early Head Start at this center. → Please complete Part 3 and Part 6.
☐ My household includes one or more foster children → Please complete Part 4 and Part 6.
☐ My child(ren) may qualify for Free or Reduced-Price meals based on household income. → Please complete Part 5 and Part 6.
☐ My child(ren) will not qualify for Free or Reduced-Price meals. → Please complete Part 6 only.

PART 2 – HOUSEHOLD MEMBER(S) RECEIVING SNAP and/or TANF BENEFITS

If any household member gets SNAP (Food Stamps) and/or TANF benefits, list the recipient's name, circle the benefit type(s), and give the case number.

Name of Benefit Recipient	Circle One or Both (if applicable)	SNAP / TANF Case Number (required—not SSN or EBT #)
	SNAP TANF	

PART 3 – CHILD(REN) ENROLLED IN HEAD START

If the enrolled child(ren) participates in Head Start/Early Head Start, write the name(s) below.

Name of Child	Name of Child	Name of Child

PART 4 – FOSTER CHILDREN

Name of Foster Child	Households with foster children only: Write the child(ren)'s name(s) here, then skip to Part 6. Households with foster & non-foster children: Write foster child(ren)'s name(s) here. If you did not complete Part 2, you must complete Part 5 to qualify non-foster child(ren) for free/reduced-price meals. You may include foster child(ren) in Part 5 with non-foster child(ren). This makes it easier for non-foster child(ren) to qualify for free/reduced-price meals. If you choose to list the foster child(ren) in Part 5, you must report any personal income received by the foster child(ren). You do not have to report payments that you receive from the placement agency to support the foster child(ren). If you completed Part 2, skip Part 5. All complete Part 6.

PART 5 – TOTAL HOUSEHOLD INCOME – Not required if Part 2 or Part 3 is completed.

Write how much income and how frequently that amount is received: weekly, every two weeks (biweekly), twice a month (semimonthly), once a month (monthly), or annually.

List Names (First and Last) of Everyone In Your Household	Gross Income (before Taxes or Deductions) from Last Month (if none, write "0")								
	Earnings From Work Before Deductions		Alimony, Child Support, Welfare, etc.		Pensions, Retirement, Social Security, VA, etc.		Second job or any other income		
	NAME	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY
1.									
2.									
3.									

PART 6 – CERTIFICATION, SIGNATURE, AND SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

The adult household member who fills out this form must sign below. If Part 5 is completed, the adult signing the form must provide the **last four (4) digits ONLY** of his/her Social Security Number (SSN), or check "I do not have a Social Security Number." (See Privacy Act Statement on the back of this page.) **The last four digits of your SSN are NOT needed if you have checked "My child(ren) will not qualify for Free/Reduced-Price meals" or if you have listed a TANF or SNAP case number or are applying for Head Start or foster child(ren) only.** **CERTIFICATION:** I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution official(s) may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

PRINTED NAME OF PARENT / GUARDIAN	(LAST 4 DIGITS ONLY): XXX – XX – _____	
SIGNATURE OF PARENT / GUARDIAN	DATE	☐ I do not have a Social Security Number
STREET ADDRESS, CITY, STATE, ZIP CODE		DAYTIME PHONE

PART 7 – CIVIL RIGHTS INFORMATION: ENROLLED CHILD(REN)'S ETHNICITY & RACE (OPTIONAL)

Check the ethnic and racial identity of your child(ren).

Ethnicity (mark one ethnic identity):

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (mark one or more racial identities):

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

This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this Program is administered without discrimination.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex (including gender identity and sexual orientation), religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, income derived all or in part from any public assistance programs, or protected genetic information in employment or any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete a USDA Program Discrimination Complaint Form, found online at http://ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410, by fax at (202) 690-7442, or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8330 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

In conjunction, the District of Columbia Human Rights Act, approved December 13, 1977 (DC Law 2-38; DC Official Code §2-1402.11(2006), as amended) prohibits discrimination on the basis of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation of any individual. Additional protected traits can be found at <https://ohr.dc.gov/protectedtraits>. To file a complaint alleging discrimination on one of these bases, please contact the District of Columbia's Office of Human Rights at (202) 727-4559 or <https://ohr.dc.gov/service/file-complaint>.

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 list a case number for the Supplemental Nutrition Assistance Program (SNAP) and/or the Temporary Assistance for Needy Families (TANF) Program, submit an application on behalf of a foster child only, 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. Verification efforts may be carried out through program reviews, audits, and investigations and may include contacting the Child and Family Services Agency to verify foster child status; contacting the Income Maintenance Administration office to confirm receipt of SNAP and/or TANF benefits; contacting employers to determine income; and/or checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY – IES CLASSIFICATION**Reimbursement classification category for foster children**

Check if one or more foster children are reported on this form:

- ☐ Free

Reimbursement classification category for non-foster children

Check one classification for all non-foster children reported on this form:

- ☐ Free (TANF, SNAP, Income Eligible, Head Start)
☐ Reduced-price
☐ Paid (household income above free or reduced-price level)
☐ Paid (incomplete information)

Total Household Income:

If necessary, use the correct income conversion formula before adding incomes reported with different frequencies. Once total monthly income is determined, write "monthly" as the frequency and use the "monthly" column of the Income Eligibility Guidelines.

To find monthly income:

Weekly income X 4.33 / every 2 weeks X 2.15 / twice a month X 2

Total income: \$ _____ Frequency: _____

Number of household members: _____

The institution's Determining Official **MUST** sign and date the IES to complete it. Signature of a Verifying Official is recommended.

Signature of Determining Official

Date

Signature of Verifying Official

Date

Date child(ren) withdrew or terminated: _____