



Stepping Stones Children's Center

www.stepstonescc.org

The Children's Center & Administrative Offices (724) 625-2199
712 Warrendale Road, Gibsonia, PA 15044
schoolage@stepstonescc.org (Deer Lakes Coordinator)
familyaccounts@stepstonescc.org (Family Accounts Manager)
Deer Lakes (412) 552-1157

Deer Lakes Before/After School Care Program 2018-2019

Please check off completed paperwork, sign, date, and submit to the Administrative Office for processing:

- Registration Form and \$50.00 Annual Registration Fee (non-refundable) + ½ months tuition to be applied to invoices for August & June. Refund will be issued for accounts with a credit balance at the end of the school year.
- Emergency Contact/Parental Consent Form (please fill in all spaces, sign and date)
- NEW ENROLLMENTS ONLY:
Child Health Assessment (Signed by a physician)
School-Age Health Assessments must be received by the Children's Center prior to the first day of school. Any Health Assessment is acceptable from Kindergarten to current grade level. See attached forms.
- Child Survey
Help your child's Site Director and Stepping Stones staff to know your child by completing this short survey.
- Income eligibility form.
- Agreement form signed and dated (**to be distributed after the above forms are returned to the Administrative Office**).
- Child Care Food Program Sheet signed and dated (**to be distributed with Agreement Form**)
I understand that my registration will not be complete and my child will not be considered enrolled until all forms are completed, signed and submitted to Stepping Stones Administrative Office and I have received a confirmation email from Stepping Stones.

Parent or Legal Guardian Signature

Date



Stepping Stones

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Deer Lakes
 Before/After School Care Program
 Tuition Policies
 2018-2019

- The Discount Rate applies to tuition payments received on or before the 1st of the month. When the 1st of the month falls on a weekend or holiday, the Discount Rate applies to tuition payments received on the last business day before the 1st of the month. Monthly invoices will be emailed 7 days prior to the beginning of each month.
- The Regular Rate applies to tuition payments received between the 2nd and 10th of the month.
- **After the 10th of the month, if tuition has not been paid, child care services may be withheld until payment is received or payment arrangements are made.**
- Annual Registration: A fee of \$50.00 per child (non-refundable) is due upon registration + Deposit equal to ½ months tuition required at time of registration to be applied to August & June invoices. Refunds will be issued at end of school year for accounts with a credit balance.
- Tuition for the first days of school in August the last day of school in June may be at a fixed rate and no discounts may apply. Invoices for these days will go out after the services have been rendered.
- If your family should have an unusual or emergency type financial problem that may affect your prompt payment, please call the Administrative Office to talk with the Executive Director. We can often arrange a payment schedule which will meet your family's needs.
- Children may be enrolled on a full-time basis, a minimum of two days per week, or on an As Needed basis. There are no sibling discount for children enrolled on an As Needed basis.
- Extra days of care are available, space permitting, with prior notification.
- For the convenience of having a variable schedule, your tuition will reflect a rate one day higher than the number of days scheduled (For example: for a 3 day variable schedule, the 4 day per week tuition rate would apply).
- A two week notice of child withdrawal is required to suspend billing and receive a refund for any unused services.
- Tuition for after school care includes an afternoon snack. Breakfast and an afternoon snack are provided on full-day In-service days, Holidays, and Snow days.
- **The center is closed and will not provide care on the following days:**

| | | | |
|------------------|---------------------|-------------------------|---------|
| Independence Day | 7/4/18 | New Year Holiday | 1/1/19 |
| Labor Day | 9/3/18 | *Martin Luther King Jr. | 1/21/19 |
| *Columbus Day | 10/8/18 | Spring Break | 4/19/19 |
| Thanksgiving | 11/22/18 + 11/23/18 | Memorial Day | 5/27/19 |
| Winter Break | 12/24/18 + 12/25/18 | | |

*Professional Development Days for Staff

- Because program expenses for center programs are consistent even when your child misses time due to illness, vacation, ect. we cannot extend tuition credit or reschedule missed days. To compensate for this fact, we build in a ½ day per month missed time factor by basing fees on a 4 week, 20 day month.
- Families are encouraged to seek information on the Federal Child Care Tax Credit, CCIS child Families are encouraged to seek information on the Federal Child Care Tax Credit, CCIS child care subsidy (for residents of Allegheny, Butler, and Beaver Counties), and Stepping Stones Recruitment Incentive Program by calling the Children's Center office at 724-625-2199.
- A \$35.00 charge will be/ assessed for each check returned unpaid due to non-sufficient funds.
- All Invoices have an online link attached for the convenience of paying online.

Providing high quality education and child care in an environment that fosters positive relationships among our children, staff, families and community we serve.

Support Stepping Stones through United Way Contributor Choice Program (#285)



**Deer Lakes
Before/After School Age Care Program
2018-2019 Tuition Schedule
Effective July 1, 2018-June 30, 2019**

| Care Provided | # Days/Week | Discounted Tuition Rate(If paid on/before the 1 st of the month) | Regular Tuition Rate (paid after the 1 st of the month) |
|--------------------------------|-------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------|
| Before School | 2 | \$136.00 | \$143.00 |
| Monthly Rates | 3 | \$202.00 | \$212.00 |
| | 4 | \$266.00 | \$279.00 |
| | 5 | \$328.00 | \$346.00 |
| Extra Day \$20.00 | | | |
| As Needed \$34.00 | | | |
| After School | 2 | \$140.00 | \$147.00 |
| Monthly Rates | 3 | \$208.00 | \$219.00 |
| | 4 | \$274.00 | \$289.00 |
| | 5 | \$338.00 | \$356.00 |
| Extra Day \$21.00 | | | |
| As Needed \$35.00 | | | |
| Before AND After School | 2 | \$212.00 | \$223.00 |
| Monthly Rates | 3 | \$310.00 | \$326.00 |
| | 4 | \$408.00 | \$429.00 |
| | 5 | \$502.00 | \$528.00 |
| Extra Day \$29.00 | | | |
| As Needed \$56.00 | | | |

- Care is provided from 6:30 AM to 6:30 PM at an offsite location on school Holidays and Snow Days. No extra charge for these days if your child is normally scheduled to attend those days. The extra day fee will be charged only for children not normally scheduled to attend on those.
- Annual Registration: A fee of \$50.00 per child (non-refundable) is due upon registration + ½ month tuition to be applied to August and June. Refund will be issued for accounts with credit balance at the end of the school year.
- Sibling Discount: A 10% off tuition for older sibling(s) is valid for children enrolled in any Stepping Stones program, excluding School-Age Summer Camp.
- Tuition for the first days of school in August and the last day of school in June may be at a fixed rate and no discounts may apply. Invoices for these days will go out after the services have been rendered.
- Late Pick-Up: Stepping Stones closes at 6:30 PM. If picking your child up after 6:30 PM becomes the routine rather than the exception, a late fee of \$10.00 per half hour or fraction thereof, will be charged. This fee is to be paid before your child returns to the facility. (Please refer to the Parent Handbook for complete Late Pick-Up Policy details).
- Non-refundable Holding Fee: If you temporarily withdraw your child from the program for one to three months, a fee equal to 15% of the tuition rate per child is payable per month. If your child's time out of the program exceeds three months, Stepping Stones reserves the right to fill your child's spot. The older sibling discount does not apply when figuring the Holding Fee. During this period of time, if you need care, the As Needed rate applies.
- Tuition Refund: A two week notice of child withdrawal is required to suspend the billing and receive a refund for any unused services.
- Recruitment Incentive Program: Save 10% off one month's tuition by referring a new family to Stepping Stones. (Please see policy for complete Recruitment Incentive Program details).
- Please make checks payable to Stepping Stones Children's Center. Checks can be given to a staff member at your child's program or mail to: Stepping Stones Children's Center 712 Warrendale Road Gibsonia, PA 15044

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**Deer Lakes
 Before/After School-Age Program
 2018-2019**

Name of Child _____ Date of Birth ____/____/____
 Parent(s) Name(s) _____
 Address _____ Phone _____
 E-mail address _____
 First day of school _____ Grade _____
 Race (optional): _____
 (For non-discrimination compliance reporting)
 Languages other than English spoken at home _____ Translator needed: Yes ____ No ____

Please check all services that apply for your child care needs:

*Please note there is a two-day minimum enrollment unless registering "As Needed".
 (All parents are required to inform their child's school office and teacher in writing of the following schedule)*

- My child will attend the Stepping Stones Before School Program:
 (From 6:30am until the start of the school day)
 Monday Tuesday Wednesday Thursday Friday As Needed
- My child will attend the Stepping Stones After School Program:
 (From the end of the school day until 6:30pm)
 Monday Tuesday Wednesday Thursday Friday As Needed

Please check all that apply for permission to use your child's image for any or all of the following:

- I give Stepping Stones Children's Center permission to use pictures of my child on their website (www.stepstonescc.org) AND to use pictures of my child on all social media with the understanding that NO NAMES will be used without additional authorization.
- I give Stepping Stones Children's Center permission to use pictures of my child for classroom use. I understand that images remain within the Stepping Stones facility and are not used for publication outside of the center.

 Parent or Legal Guardian Signature

| | |
|-----------------------------------|------------------|
| <i>Administrative Staff Only:</i> | |
| _____ SA Coordinator | Check # _____ |
| _____ Family Accounts | Subsidized _____ |
| _____ Procure | |

***50.00 registration fee + ½ months deposit (to be applied to August & June Tuition) required with this form.**

EMERGENCY CONTACT / PARENTAL CONSENT FORM

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

| | | |
|------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------|
| CHILD'S NAME | | BIRTHDATE |
| ADDRESS | | |
| PARENT/LEGAL GUARDIAN | | HOME TELEPHONE NUMBER |
| ADDRESS | | CELL PHONE NUMBER |
| BUSINESS NAME | | BUSINESS TELEPHONE NUMBER |
| BUSINESS ADDRESS | EMAIL ADDRESS | |
| PARENT/LEGAL GUARDIAN | | HOME TELEPHONE NUMBER |
| ADDRESS | | CELL PHONE NUMBER |
| BUSINESS NAME | | BUSINESS TELEPHONE NUMBER |
| BUSINESS ADDRESS | EMAIL ADDRESS | |
| EMERGENCY CONTACT PERSON(S) | | TELEPHONE NUMBER WHEN CHILD IS IN CARE |
| | | |
| | | |
| PERSON(S) TO WHOM CHILD MAY BE RELEASED | ADDRESS | TELEPHONE NUMBER |
| | | |
| | | |
| NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER | | TELEPHONE NUMBER |
| ADDRESS | | |
| SPECIAL DISABILITIES (IF ANY) | | ALLERGIES (INCLUDING MEDICATION REACTION) |
| MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION | | MEDICATION, SPECIAL CONDITIONS |
| ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD | | |
| HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS | | POLICY NUMBER (REQUIRED) |
| PARENT/LEGAL GUARDIAN SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT - PLEASE SIGN OR INDICATE "NO" | | |
| OBTAINING EMERGENCY MEDICAL CARE <small>Including calling an ambulance</small> | | ADMINISTRATION OF MINOR FIRST - AID PROCEDURES <small>Includes Bandages, Ice Packs, CPR, Hand Sanitizer</small> |
| WALKS AND TRIPS <small>Includes going to the playground</small> | | SWIMMING |
| TRANSPORTATION BY THE FACULTY <small>Includes Field Trips/Emergency Evacuation</small> | | WADING |

SIGNATURE OF PARENT OR GUARDIAN

DATE

Periodic Review

SIGNATURE OF PARENT OR GUARDIAN

DATE

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

| | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------|
| CHILD'S NAME: (LAST) | (FIRST) | PARENT/GUARDIAN: |
| DATE OF BIRTH: | HOME PHONE: | ADDRESS: |
| CHILD CARE FACILITY NAME: Stepping Stones Children's Center | | |
| FACILITY PHONE: (724) 625-2199 - Administrative Office | COUNTY: | |
| <input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child. | | WORK PHONE: |
| PARENT'S SIGNATURE: | | |

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

| DO NOT OMIT ANY INFORMATION | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------|----------|
| This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form. | | | | | | |
| HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): O NONE | | | | | | |
| DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. O NONE | | | | | | |
| CHILD'S ALLERGIES (DESCRIBE, IF ANY): O NONE | | | | | | |
| LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES. O NONE | | | | | | |
| IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? O YES O NO IF NO, PLEASE EXPLAIN YOUR ANSWER: | | | | | | |
| HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? SCHEDULE AT WWW.AAP.ORG | | | NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY. | | | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO (SEE _____) | | | VISION (subjective until age 3) | | | |
| | | | HEARING (subjective until age 4) | | | |
| | | | LEAD | | | |
| RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD | | | | | | |
| IMMUNIZATIONS | DATE | DATE | DATE | DATE | DATE | COMMENTS |
| HEP-B | | | | | | |
| ROTAVIRUS | | | | | | |
| DTAP/DTP/TD | | | | | | |
| HIB | | | | | | |
| PNEUMOCOCCAL | | | | | | |
| POLIO | | | | | | |
| INFLUENZA | | | | | | |
| MMR | | | | | | |
| VARICELLA | | | | | | |
| HEP-A | | | | | | |
| MENINGOCOCCAL | | | | | | |
| OTHER | | | | | | |
| MEDICAL CARE PROVIDER: | | | | SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT | | |
| ADDRESS: | | | | TITLE: | | |
| PHONE: | | | LICENSE NUMBER: | | DATE FORM SIGNED: | |

Help Us To Know Your Child
(This form will go to the Site Director(s) of your child's school)

2018-2019

Name of Child _____ Date of Birth _____

Parent/Guardian's Names _____

Address _____

First Contact Phone Number _____ Grade _____ Age _____

(The number you would like us to call first in the event we need to get a hold of you)

What does your child like to be called? ie: nickname _____

Care Needed: _____

Before School _____ to 8:45am M _____ T _____ W _____ R _____

After School 3:00pm to _____ M _____ _____ _____ _____

Does your child have any special needs?

Physical: _____

Medication: _____

Food/Diet Restrictions: _____

What activities does your child enjoy doing most?

How long will your child spend at an activity that he/she enjoys?

What techniques are effective when your child is upset?

Does your child have any concerns/fears about entering this program?

Please give us any other information that you feel would be helpful for us to know about your child.

Parent/Legal Guardian Signature

Date



Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Stepping Stones Children's Center offers healthy meals to all children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

- 1. Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household only if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all the required information. **Return the completed form to: Stepping Stones Children's Center.**
- 2. Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for reduced price meals.
- 3. Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits of the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.
- 4. May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You and your child do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
- 5. Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.
- 6. How do I report income information and changes in employment status?** The income you report must be the total gross income listed, by source, each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, or FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
- 7. What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
- 8. What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income.
- 9. We are in the military, do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability. If you have other questions or need help, call 724-625-2199.

CACFP Meal Benefit Income Eligibility Form
Letter to Provider (Tier I or Provider's Own Children)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.

Part 2: List the case number for any household members (including adults) receiving [State SNAP] or [State TANF] or [FDPIR] benefits.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.

Part 6: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. A Social Security Number is **not** necessary.

Part 6: Answer this question if you choose to.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have a case number, skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [your school, homeless liaison, migrant coordinator]. If not, skip this part.

Part 4: Follow these instructions to report total household income form this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the “No Income Box.”

Part 2: Skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [your school, homeless liaison, migrant coordinator]. If not, skip this part.

Part 4: Follow these instructions to report total household income form this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran’s (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker’s Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn’t have one.

Part 6: Answer this question if you choose.

This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

Child and Adult Care Food Program Child Care Center Meal Benefit Income Eligibility Form

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

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

| | | |
|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| Mark one ethnic identity: | Mark one or more racial identities: | |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Black or African American | | |
| Don't fill out this part. This is for official use only. | | |
| Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12 | | |
| Total Income: | Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year | Household size: _____ |
| Categorical Eligibility: ___ Date Withdrawn: _____ | Eligibility: Free _____ Reduced _____ Denied _____ | Tier I _____ Tier II _____ |
| Reason: _____ | | |
| Temporary: Free _____ Reduced _____ | Time Period: _____ | (expires after _____ days) |
| Determining Official's Signature: _____ | Date: _____ | |
| Confirming Official's Signature: _____ | Date: _____ | |
| Follow-up Official's Signature: _____ | Date: _____ | |

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

| Household size | Yearly |
|-------------------------|----------|
| 1 | \$22,311 |
| 2 | \$30,044 |
| 3 | \$37,777 |
| 4 | \$45,510 |
| 5 | \$53,243 |
| 6 | \$60,976 |
| 7 | \$68,709 |
| 8 | \$76,442 |
| Each additional person: | \$7,733 |

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

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Recruitment Incentive Program 2018-2019

Realizing that Stepping Stones families are our best advertisers, Stepping Stones Children's Center provides an incentive for referral of new families to our Extended Day Care Program, Kindergarten Care Program and Before/After School-Age Program. A ten percent (10%) discount off one month's tuition will be credited to the account of a family who refers a new family to one of these programs. The discount will be applied to the oldest child's tuition if more than one child is enrolled in our program. The new family must be enrolled for a minimum of three (3) Months for the credit to be awarded. Please return this form to Stepping Stones Children's Center Family Accounts Manager after the new family has attended our program for (3) months to receive your discount.

Recruitment Incentive Program Form

Your Name _____

Your Phone Number _____

Name of Family Referred by You _____

Your Signature and Date _____

Electronic Signature Not Acceptable Must be Original

Office Use Only

Date of Child's Enrollment _____

Program – Ext Day _____ Kindergarten _____ School-Age _____

Please return this form to Stepping Stones Office (712 Warrendale Road, Gibsonia, PA 15044), After the new family has been enrolled for (3) months in our program.