Child and Adult Care Food Program
ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
John Smith	xx/xx/xxxx	X	Sun (Mon) (Tu) (Wed) (Th) Fri Sat Normal Hours 8:45 to 3:30	(Breakfast) A.M. Snack (Lunch) (P.M. Snack) Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ______ to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- [x] A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)
- [ ] One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- [x] My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)
- [ ] My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR—
Any household member receiving benefits can establish eligibility for all children in the household.

Case Number or Identification Number: 000-00-0000

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1. Sally Su	$0.00	☐	☐	☐	☐	$0.00	☐	☐	☐	☐	$0.00	☐	☐	☐	☐
2. John Smith	$0.00	☐	☐	☐	☐	$100.00	☐	☐	☐	☒	$0.00	☐	☐	☐	☐
3. John Doe	$400.00	☒	☐	☐	☐	$0.00	☐	☐	☐	☐	$0.00	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

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

Signature of Adult	Today's Date	Print Name of Adult Signing
x SIGN HERE	XX/XX/XX	PRINT Name Social Security Number (SSN) (last four digits) XXX-XX- 1234 ☐ Check if no SSN
Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

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

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

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

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

FAX: 202-690-7442
EMAIL: program.intake@usda.gov

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

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced Price ☐ Paid

Household Size: ______________

Total Income: $______________
☐ Annual ☐ Monthly ☐ Twice Per Month ☐ Every Two Weeks ☐ Weekly

X______________________________
Signature of Determining Official

____
Today's Date

X______________________________
Signature of Confirming Official

____
Today's Date

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.

CCL. 035
Rev. 8/2011

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax: (785) 296-0803
Website: www.kdheks.gov/kidsnet

Kansas
Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS GROUP OF CHILDREN TO ONE LOCATION

Name of Facility (exactly as stated on the license) Social Stars Learning Center			License #
Street Address of Facility	City	Zip Code	County

Children or Youth listed below may go on an off-premise trip to:____________________

Located at:____
Street City County

on ____________________.
(MM/DD/YYYY)

Time of Departure:________________ Estimated Time of Return:________________

Children or Youth will be traveling by: X Vehicle ______ Walking

Children or Youth will be supervised at all times by the following staff:

Staff Name____________________ Staff Name ____________________
First Last First Last

Staff Name ____________________ Staff Name ____________________
First Last First Last

FIRST AND LAST NAME OF CHILD OR YOUTH	PARENT/GUARDIAN SIGNATURE GRANTING PERMISSION (Include First and Last Name)
John Smith	SIGN HERE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize South Central Mental Health Counseling Center, Inc. (SCMHCC), 520 E. Augusta Ave., Augusta, KS 67010 to share protected health information with the identified third party for the purposes of treatment, payment and health care operations.

CLIENT:

Smith — John — XX/XX/XX

Last Name — *First Name* — *MI* — *Date of Birth*

I authorize SCMHCC to (initial all that apply):

☐ **exchange** ☐ **release to** ☐ **obtain from** JS ☒ **discuss with**

the third party identified below, specified protected health information listed below for the purposes of treatment, payment & health care operations.

INITIAL EACH APPLICABLE ITEM:

- ☐ Billing and/or Insurance Information
- ☐ Intake/Admission Summary
- ☐ Diagnosis
- ☐ Psychiatric Evaluation
- ☐ History & Physical
- JS ☒ Medication List
- ☐ Treatment Review/Progress Report
- ☐ Discharge Summary
- JS ☒ Treatment Plan/Plan of Care
- ☐ Psychological Testing
- ☐ School Records
- ☐ Progress Notes
- ☐ Waiver Documents
- ☐ Lab Reports
- ☐ Chemical Dependency Evaluation
- ☐ Alcohol/DUI Evaluation

☐ Other: __________

THIRD PARTY:

Doctors Name — Primary Care Physician

Organization/Individual Name — *Relationship to Client*

Address

123-345-5678

Telephone/Fax

This authorization shall remain in effect until__________ *(date)* at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time *(except to the extent that action has been taken in reliance upon it)* by providing verbal or written notice of revocation to SCMHCC.

Signature of Client — *Date*

Printed Name of Client — *Address and Phone Number*

SIGN HERE — XX/XX/XX

Signature of Client Guardian — *Date*

Printed Name of Client Guardian and Relationship to Client — *Guardian Address and Phone Number*

Signature of Witness

☐ **Client verbally revoked ROI on:** __________ **Staff Signature and Date:** __________

☐ **Authorization revoked by client or guardian by attached statement dated:** __________ **; or,**

☐ **I hereby revoke the above authorization to release confidential information.**

Signature of Client (age 14 or older) — *Signature of Client Guardian* — *Date*

Revocation Disclaimer Substance Abuse Only:

If my treatment was mandated by the court, permission to release to the court cannot be revoked until I am officially released from confinement, parole or probation.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize South Central Mental Health Counseling Center, Inc. (SCMHCC), 520 E. Augusta Ave., Augusta, KS 67010 to share protected health information with the identified third party for the purposes of treatment, payment and health care operations.

CLIENT:

Smith	John		XX/XX/XXXX
Last Name	*First Name*	*MI*	*Date of Birth*

I authorize SCMHCC to (initial all that apply):

☐ **exchange** ☐ **release to** ☐ **obtain from** XX ☒ **discuss with**

the third party identified below, specified protected health information listed below for the purposes of treatment, payment & health care operations.

INITIAL EACH APPLICABLE ITEM:

- ☐ Billing and/or Insurance Information
- ☐ Intake/Admission Summary
- ☐ Diagnosis
- ☐ Psychiatric Evaluation
- ☐ History & Physical
- ☐ Medication List
- ☐ Treatment Review/Progress Report
- ☐ Discharge Summary
- XX ☒ Treatment Plan/Plan of Care
- ☐ Psychological Testing
- ☐ School Records
- ☐ Progress Notes
- ☐ Waiver Documents
- ☐ Lab Reports
- ☐ Chemical Dependency Evaluation
- ☐ Alcohol/DUI Evaluation

XX ☒ Other: Pick up / drop off

THIRD PARTY:

NAME -	EMERGENCY CONTACT
Organization/Individual Name	*Relationship to Client*

Address

Phone number

Telephone/Fax

This authorization shall remain in effect until______________ *(date)* at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time *(except to the extent that action has been taken in reliance upon it)* by providing verbal or written notice of revocation to SCMHCC.

Signature of Client — *Date*

Printed Name of Client — *Address and Phone Number*

SIGN HERE — XX/XX/XXXX

Signature of Client Guardian — *Date*

Printed Name of Client Guardian and Relationship to Client — *Guardian Address and Phone Number*

Signature of Witness

☐ **Client verbally revoked ROI on:** __________ **Staff Signature and Date:** __________

☐ **Authorization revoked by client or guardian by attached statement dated:** __________ **; or,**

☐ **I hereby revoke the above authorization to release confidential information.**

Signature of Client (age 14 or older) — *Signature of Client Guardian* — *Date*

Revocation Disclaimer Substance Abuse Only:

If my treatment was mandated by the court, permission to release to the court cannot be revoked until I am officially released from confinement, parole or probation.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CCL.026
Rev. 5/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

Authorization for Dispensing Medications to Children and Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child/youth designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1

John Smith — XX/XX/XXXX
First and Last Name of Child/Youth — Date of Birth

Sunscreen
Name of Medication

Sun protection
Reason for Medication

As needed — n/a
Dose — Time to be Given — Stop Date

n/a
Name of Licensed Physician/PA/APRN prescribing the medication

(_______)
Phone Number of Physician, PA, or APRN

I allow the above medication to be given to my child/youth by the designated person.

SIGN HERE — XX/XX/XX
Parent's Signature — Date

Medication #2

John Smith — XX/XX/XXXX
First and Last Name of Child/Youth — Date of Birth

Amoxicillin
Name of Medication

Antibiotic
Reason for Medication

5ml — 11:30 AM — XX/XX/XX
Dose — Time to be Given — Stop Date

Doctor Doctor
Name of Licensed Physician/PA/APRN prescribing the medication

(123) 345-5078
Phone Number of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

SIGN HERE — XX/XX/XX
Parent's Signature — Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

***Each designated person administering medication is to sign on the back side of this form and identify initials used above.**

*Signature of Designated Person Administering Medication ______________________________ Initialing as________

*Signature of Designated Person Administering Medication ______________________________ Initialing as________

*Signature of Designated Person Administering Medication ______________________________ Initialing as________

*Signature of Designated Person Administering Medication ______________________________ Initialing as________

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.

CCL.027
Rev. 5/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

Authorization for Dispensing Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

John Smith
First and Last Name of Child/Youth

XX/XX/XXXX
Date of Birth

Quillivant
Name of Medication (only one medication per authorization)

Prescription
Prescription OR Non Prescription

ADHD
Reason for Medication

4ml
Dose

11:30 am, 2pm
Time to be Given

1/1/21 XX/XX/XXX
Start Date

1/1/22
Stop Date**

Dr. Krehbiel (prescribing doctor)
Name of Licensed Physician, PA or APRN prescribing the medication

123-345-5678
Phone # of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

SIGN Here
Parent's Signature

XX/XX/XX
Date Signed

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Designated Person to note any comments or remarks about the child's/youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

***Each designated person administering medication is to sign on the back side of this form and identify initials used above.**

*Signature of Designated Person Administering Medication ________________________________ Initialing as__________

*Signature of Designated Person Administering Medication ________________________________ Initialing as__________

*Signature of Designated Person Administering Medication ________________________________ Initialing as__________

*Signature of Designated Person Administering Medication ________________________________ Initialing as__________

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.