COSTARS
EARLY CHILDHOOD SERVICES

Camp-I-Can Enrollment Packet

Summer 2022

Child Information

Child's Name: _____ **Desired Start Date:** _____

Date of Birth: _____ **Age:** _____ **Gender:** ❑ Male ❑ Female

Race: ❍ Alaskan Native ❍ American Indian ❍ Asian ❍ Biracial/Multiracial ❍ Black or African American ❍ Hawaiian/Pacific Islander ❍ White

Ethnicity: ❍ Not Hispanic or Latino ❍ Hispanic or Latino

Child's Current School (for school age): _____

Child' Current Grade (for school age): _____

Anticipated Schedule: Drop Off Time: _____ Pick Up Time: _____

Payment Method: ❑ Private Pay ❑ Employee ❑ Hamilton County JFS Child Care Vouchers*

JFS Case #: _____ *Vouchers must be in place prior to the first day of care.

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more:

❍ Often True ❍ Sometimes True ❍ Never True

Current Annual Household Income (before taxes are taken out):

❍ Less than $10,000 ❍ $10,000 to $14,999 ❍ $15,000 to $24,999 ❍ $25,000 to $34,999
❍ $35,000 to $49,999 ❍ $50,000 to $74,999 ❍ $75,000 to $99,999 ❍ $100,000 or more

Number of People in Household (whether they receive an income or not): _____

Is this a female headed household? ❍ Yes ❍ No

Is mother/father/guardian a U.S. Veteran? ❍ Yes ❍ No

Has your child previously attended or is currently attending or working with another program provided by Best Point Education & Behavioral Health?

❑ Counseling ❑ Day Treatment ❑ Other _____

I, the undersigned, do hereby state and declare under penalty of falsification (*) that I am the parent or legal guardian of the child named on this form and that this registration information is true and correct.

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

(*) Falsification under Ohio Revised Code section 2921:13 is a misdemeanor of the first degree punishable by a maximum of six months imprisonment or a fine of $1,000 or both.

Getting to Know My Child

Thank you for choosing CoStars Early Childhood Services for your child. In order to ensure that your child has a positive experience with us, we are asking that you provide the following information. This will help ensure that we are prepared in advance to meet your child's needs and provide the best possible experience.

Child's Name: _____ **Date of Birth:** _____

What are your hopes for your child and family in this program?

_____

What are your expectations for our program?

_____

Do you have any concerns about your child's learning? Please include any subjects they find difficult.

_____

MEDICAL HISTORY	**YES**	**NO**
Has your child had any broken bones, head injuries, burns or poisoning? If yes, what type and when: _____		
Has your child ever had lead poisoning?		
Has your child ever been abused?		
Do you have concerns about your child's speech?		
Do you have concerns about your child's vision?		
Do you have concerns about your child's hearing?		
Has your child received any evaluations such as Psychological, Neurological or Speech?		
Has your child ever had Pressure Equalizer (PE) Tubes?		

MENTAL HEALTH DIAGNOSIS	**YES**	**NO**	**EDUCATION DISABILITIES**	**YES**	**NO**
ADHD			Autism Spectrum Disorder		
Attachment Disorder			Cognitive Development		
Bipolar			Emotional Disturbances		
Conduct Disorder			Hearing Impairment		
Emotional Disturbances			Learning Disability		
Mood Disorder			Multiple Handicapped		
ODD			Visual Impairment		
Other:			Down Syndrome		

If "YES" to any condition listed, please explain:

_____

_____

_____

List three words to describe your child:

_____

Who is in the child's immediate family?

_____

Who lives at the home with your child?

_____

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

_____

Are there any changes or transitions that your child has recently experienced or is currently experiencing? (moved from crib to bed, divorce, death of someone close, a recent move)

_____

_____

Does your child, or your household, have a second language? If so, what is it?

_____

What can we learn about your culture to be as respectful as possible? We also like to build lesson plans around these so everyone can learn.

_____

_____

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

_____

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

_____

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

_____

ROUTINES	**YES**	**NO**
Can your child decide when they need to go to the bathroom?		
Do they need a reminder to go to the bathroom?		
Do they need help with dressing themselves?		
Can your child feed themselves entirely?		
Does your child nap during the day? If yes, how long? _____		

Tell us about your child's nap time routines:

_____

_____

LIKES OR DISLIKES	Please describe your child's likes or dislikes in space provided:
Favorite activities	
Favorite toys/games	
Favorite foods	

Strong dislikes:

FRIENDSHIPS **Please rate the following statements regarding your child's interactions with other children:**	**Never**	**Sometimes** 1x -2x a month	**Often** 1x -2x a week	**Most times** daily	**Not Sure**
Is liked by other children and makes friends easily	0	1	2	3	NA
Engages other children in conversation or play	0	1	2	3	NA
Shares and respects belongings of other children	0	1	2	3	NA
Maintains good physical space with other children	0	1	2	3	NA
Argues with other children	0	1	2	3	NA
Blames others for mistakes or misbehaviors	0	1	2	3	NA
Is touchy or easily annoyed by others	0	1	2	3	NA
Physically fights with other children	0	1	2	3	NA
Bullies, threatens or intimidates others	0	1	2	3	NA

Please add any additional information about your child's interactions with other children:

SELF-CONTROL **Please rate the following statements regarding your child's abilities to manage behaviors:**	**Never**	**Sometimes** 1x -2x a month	**Often** 1x -2x a week	**Most times** daily	**Not Sure**
Is able to name and talk about feelings	0	1	2	3	NA
Is able to wait and take turns	0	1	2	3	NA
Participates in quiet activities or independent play	0	1	2	3	NA
Becomes easily frustrated and gives up	0	1	2	3	NA
Throws or destroys things when angry	0	1	2	3	NA
Loses temper	0	1	2	3	NA

Are their specific events or triggers that lead to certain behaviors?

How do you handle these behaviors?

In what ways, if any, will your child need specialized assistance from the staff?

ATTENTION TO TASK **Please rate the following statements regarding your child's abilities to complete tasks:**	**Never**	**Sometimes** 1x -2x a month	**Often** 1x -2x a week	**Most times** daily	**Not Sure**
Stays focused on what needs to be done	0	1	2	3	NA
Is able to organize tasks and activities	0	1	2	3	NA
Remembers and follows directions	0	1	2	3	NA
Does not pay attention to details and makes careless mistakes	0	1	2	3	NA
Loses things needed for activities or tasks	0	1	2	3	NA
Is easily distracted by noises or other stimuli	0	1	2	3	NA

Please add any additional information about your child's attention to task:

What can we do to help your child complete tasks?

RELATIONSHIPS WITH ADULTS **Please rate the following statements regarding your child's interactions with adults:**	**Never**	**Sometimes** 1x -2x a month	**Often** 1x -2x a week	**Most times** daily	**Not Sure**
Is trusting of adults	0	1	2	3	NA
Asks adults for help or for what is needed	0	1	2	3	NA
Follows directions	0	1	2	3	NA
Argues with adults	0	1	2	3	NA
Lies to get out of trouble	0	1	2	3	NA
Pushes, kicks or hits adults when angry	0	1	2	3	NA

Please add any additional information about your child's interactions with adults:

What can we do to make sure we form a positive relationship with your child?

WORRIES OR FEARS **Please rate the following statements regarding your child's worries or fears:**	**Never**	**Sometimes** 1x -2x a month	**Often** 1x -2x a week	**Most times** daily	**Not Sure**
Is confident and at ease in new situations	0	1	2	3	NA
Is able to try new things	0	1	2	3	NA
Is self-conscious and easily embarrassed	0	1	2	3	NA
Feels lonely or disliked by others	0	1	2	3	NA
Is fearful, anxious or worried	0	1	2	3	NA

How does your child handle change?

How do you comfort your child?

What other important information would you like our staff to know about your child?

_____

_____

_____

_____

_____

_____

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Notice of Privacy Practices & Acknowledgement of Receipt

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions, please contact our Privacy Officer, at (513) 272-2800.

Who will follow this notice?
Best Point Education & Behavioral Health (Best Point) provides health care to our clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care, mental health, or social service professional that provides services to you at any of our locations.
- All departments and units of our organization, including: the Behavioral Health Services Department and Every Child Succeeds Program and all locations of these departments and programs.
- All employed associates, staff or volunteers of the Behavioral Health Services Department and the Every Child Succeeds Program.
- Any business associate or partner of Best Point with whom we share health information.

Our pledge to you.
We understand that health care information about you is personal. We are committed to protecting health care information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep health care information about you private.
- Give you this notice of our legal duties and privacy practices with respect to health care information about you.
- Follow the terms of the notice that is currently in effect.

Changes to this Notice.
We may change our policies at any time. Changes will apply to health care information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our website at www.tchcincy.org

You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose health care information about you.

- We may use and disclose health care information about you for treatment (such as sending health care information about you to a specialist as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicaid); and to support our health care operations (such as comparing client data to improve treatment methods.)
- We may use or disclose health care information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out health care information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies. We also disclose health care information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.
- We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you, or to support fundraising efforts (provided that we give you the opportunity to opt out of future fundraising efforts).
- We may disclose health care information about you to a friend or family member who is involved in your medical care, or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of health care information.
In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing health care information about you. For example, although we are unlikely to ever do so, if we share your health care information for marketing purposes or if your health care information includes psychotherapy notes, we must get your written authorization

before using or disclosing such information. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding health care information about you.

- In most cases, you have the right to look at or get a copy of health care information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the health care information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclosed health care information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.
- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that health care information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request, in writing, that we not use or disclose health care information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. In most cases, we will consider your request but we are not legally required to accept it. We will inform you of our decision on your request. The one exception is that, under new rules, if you pay entirely for a service 'out of pocket,' we must honor your request to not share information about that service with your insurance company or other payer.
- You now have a right to be notified following a breach of your unsecured heath information.

All written requests or appeals should be submitted to our Privacy Officer (contact information listed below).

Complaints

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (contact information listed below).
- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you the address.
- Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer
Best Point Education & Behavioral Health
5050 Madison Road, Cincinnati Ohio 45227
(513) 272-2800

By signing this form, I acknowledge receipt of the Notice of Privacy Practices.

_____	_____
Name of Child	Date of Birth

_____	_____	_____
Name of Responsible Party	Signature of Responsible Party	Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Client Rights Notice, Grievance Procedure & Acknowledgement of Receipt

We place high value on you, as a client of Best Point Education & Behavioral Health***, and pledge to respect your rights as listed below.***

RIGHT	DESCRIPTION
1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.	*You have the right to be free from physical, sexual, and emotional abuse. If you are not sure if it is abuse, ask your Client Rights Officer or someone you trust.*
2. The right to service in a humane setting which is the least restrictive feasible, as defined in the treatment plan.	*You can't be committed to a hospital or put in a quiet room unless there is no other treatment to help you to be safe to yourself and others. As soon as it is safe, you must be given more freedom.*
3. The right to be informed of one's own condition, of proposed or current services, treatments or therapies and the alternatives.	*You have the right to ask questions and the right to know what's going on.*
4. The right to consent to refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of the child.	*You can say yes or no to any service or treatment. A parent or guardian may do this on behalf of a child.*
5. The right to a current, written individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.	*You must have a plan which meets your needs. It is your road map to getting on with life.*
6. The right to active and informed participation in the establishment, periodic review and reassessment of the service plan.	*You or a parent or guardian must be permitted to help create or change your plan.*
7. The right to freedom from unnecessary or excessive medication.	*Taking medication is your choice. If you refuse some or all of your medication, you will not lose other rights or services.*
8. The use of physical restraint or seclusion is a measure of last resort to prevent harm to you or others.	*You will not be put in a physical restraint or in a quiet room as punishment. This will only happen when you are out of control in a potentially dangerous way to yourself or others and other means to try to help you have failed. You will not be 'sent to your room' although you can be asked to leave a common area for a time, or others asked to leave a common area to ensure your safety or the safety of others.*
9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity will be explained to the client and written in the case record.	*You may pick and choose which services you participate in. Saying no to any service, will not keep you from receiving another service. Past performance in a service does not keep you from taking part in that or other services.* *If you are not allowed a service, this will be explained to you and written in your case record.*
10. The right to be informed of and refuse any unusual or hazardous treatment procedures.	*You (or your parent/guardian) must be told of special or risky treatments and can make the decision not to have them.*
11. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, movies or photographs.	*Nobody can take your picture or record you in a mental health setting without your (or your parent/guardian's) permission.*
12. The right to have the opportunity to consult with independent treatment specialists or legal counsel at one's own expense.	*You can have your own doctor, counselor or lawyer, but usually you must pay for it.*
13. The right to confidentiality of communications and of all identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client, parent or legal guardian of the child.	*There are rules about who may see your records. These rules protect you from having people tell private information without your permission (or the permission of your parent/guardian).*

RIGHT	DESCRIPTION
14. The right to have access to one's own records, unless restricted by adoption statutes or there are clear treatment reasons for denying access. When access is denied to specific information, the treatment plan indicates what information is restricted and the reasons for the restriction. 'Acceptable reason for restriction' means that severe emotional damage will be done to the client, such that dangerous or self-injurious behavior is an eminent risk. The client or others authorized to have the information are informed about the restriction and the specific reasons for it. The restriction is valid for up to one year and thereafter must be re-issued with appropriate procedures followed. Any person authorized in writing by the client and professionally qualified to do so has unrestricted access to all information.	*In most cases, You (or your parent/guardian) may see or get a copy of your own records. If you are denied the right to see your records, you have the right to check with a Client Rights Officer to see if the denial is valid.*
15. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of discontinuance.	*You cannot be kicked out of a program or service. You must be told why and assisted in finding another service and/or provider.*
16. The right to receive an explanation of reasons for denial of service.	*You must know why an agency will not serve you.*
17. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or ability to pay.	*Everyone is welcome. If you have special needs, they will be accommodated.*
18. The right to know the cost of services.	*You or your parent/guardian must be told what, if anything, a service will cost. A parent/guardian will be asked to sign a fee agreement.*
19. The right to be fully informed of all rights.	*Your rights will be explained to you and you will be given a copy. If you lose your copy, you may have another. If you like, your rights can be read to you.*
20. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service.	*If you have a complaint, you can speak up without losing services.*
21. The right to file a grievance.	*If you are not satisfied with the outcome when you make a complaint, you may make your complaint formal by contacting the Client Rights Officer.*
22. The right to have oral and written instructions for filing a grievance.	*If you need help making a formal complaint, we will provide that to you.*

If you feel one or more of your rights has been infringed upon, you have a right to file a grievance with our Client Rights Officer:

Client Rights Officer
Best Point Education & Behavioral Health
5050 Madison Road, Cincinnati, Ohio 45227
(513) 272-2800

If you have any questions, please ask any staff member. He/She will explain any aspect of our Client Rights or our grievance policy and procedure. You may also contact one or more of the following boards or government agencies:

Hamilton County Mental Health and Recovery Services Board 2350 Auburn Ave, Cincinnati, OH 45219 (513) 946-8600; (513) 946-8610 (fax) http://hcmhrsb.org/	U.S. Department of Health & Human Services Office for Civil Rights - Region V 233 N. Michigan Ave, Suite 240, Chicago, IL 60601 (800) 368-1019 (toll free); (312) 886-1807 (fax) www.hhs.gov/ocr/office
State Board of Psychology 77 S. High St, Suite 1830, Columbus, OH 43215-6108 (877) 779-7446 (toll free); (614) 728-7081 (fax); www.psychology.ohio.gov	Ohio Board of Nursing 17 S. High St, Suite 400, Columbus, OH 43215-7410 (614) 466-3947; (614) 466-0388 (fax) www.state.oh.us/nur

Ohio Department of Mental Health & Addiction Services Client Advocacy Coordinator 30 E. Broad St, 8th Floor, Columbus, OH 43215-3430 (614) 466-2596; (877) 275-6364 (toll free) www.mha.ohio.gov	State of Ohio Counselor, Social Worker and Marriage & Family Therapist Board 50 West Broad St, Suite 1075, Columbus, OH 43215-5919 (614) 466-0912; (614) 728-7790 (fax) www.cswmft.ohio.gov
Disability Rights Ohio 50 W. Broad St, Suite 1400; Columbus, OH 43215-5923 (614) 466-7264; (800) 282-9181 (toll free) www.olrs.ohio.gov	State Medical Board of Ohio 30 East Broad St, 3rd Floor, Columbus, OH 43215-6127 (614) 466-3934; (614) 728-5946 (fax); (800) 554-7717 (toll free) http://med.ohio.gov/consumer.htm

Grievance Procedure

The goal of the grievance procedure is to achieve fairness, dignity, opportunities for conciliation, and an atmosphere of mutual respect. It is the intent of the procedure that all clients are provided with access to someone who will hear their complaints fairly, should they choose to work on their concern through a formal process.

If your concern addresses alleged abuse or neglect, it is required that it be reported immediately to the Hamilton County Department of Human Services for its investigation.

The assigned primary service provider is your initial contact person within the agency. Any concerns you or a member of your family have about your care or your child's care can be addressed to the primary service provider at any time. If your concerns are not addressed to your satisfaction by the primary service provider, you may go to the Program Manager, and then to the Department Director.

If your concerns are not answered to your satisfaction by the program staff, you may contact the Client Rights Officer by calling (513) 272-2800 or writing to Best Point Education & Behavioral Health, 5050 Madison Road, Cincinnati, Ohio 45227. The Client Rights Officer will assist you through the complaint process. You have the right to a representative for the entire grievance process or for any part of it. If you would like a representative but don't have anyone to call on, the Client Rights Officer will either serve as your representative or help identify someone who will represent your interests, as you see them, and who will make sure you have all of your questions answered.

If you choose to file a formal, written grievance, it will be reviewed within seventy-two hours by the Client’s Rights Officer, or their designee. The reviewer(s) will assess the validity of your grievance, ascertain the facts in the situation, and discuss it with all parties involved. The reviewer(s) will then provide a resolution and an explanation in writing within twenty working days of the original filing. You may appeal to the President & CEO of Best Point Education & Behavioral Health and a response will be given within forty-eight hours of being received. The President & CEO will have final authority to evaluate and resolve the grievance. A copy of the agency response to the grievance will be placed in the client record.

There will be absolutely no reprisals against anyone making a complaint or filing a formal grievance. Filing a grievance will in no way have any bearing on the continuance of services to you, your child, or members of your family. We are interested in knowing about your concerns so that we can continue to work effectively with you and your family to provide the highest quality of care possible.

Acknowledgement

By signing this form, I acknowledge receipt of the Client Rights Notice and the Grievance Procedure.

_____ _____

Name of Child Date of Birth

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

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Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation**.**

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**OR** **Do not sign both**	**Do Not Give Permission to Transport**	
Program or Home Name **CoStars Early Childhood Services**				Program or Home Name **CoStars Early Childhood Services**	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.				**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date			Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

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

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

COVID-19 Waiver

CoStars Early Education Services have implemented the following precautions to programs to minimize the risk of exposure to the Coronavirus and other common illnesses:

- Each family will be asked to complete a screening upon arrival to the program.
- Each child and each employee's temperature will be taken upon arrival. A temperature can be checked twice if needed.
- Anyone with a fever of 100 or above will be asked to immediately go home and remain home until he or she has been fever-free without medication for at least 24 hours
- Limit the use of shared space
- Only allow essential personnel to access the group care spaces
- All areas will be thoroughly disinfected after the program closes daily. This includes running a disinfecting fogger as a part of this cleaning protocol
- Employees have access to disinfectant throughout the day as needed and will routinely clean and sanitize high touch areas
- Employees will wash their hands regularly and encourage children to do the same. Sinks are available in each classroom and hand sanitizer is available throughout the building
- All employees who are sick will be asked to stay home
- Personal protective equipment (masks) is required for all staff and children and required for all non-direct service staff. Personal Protective stations are available at the entrance to each building
- All employees will follow all precautions from our President, the State of Ohio, Health Department and Center for Disease Control onsite and offsite
- Confirmed COVID-19 cases must be reported to ODJFS and the local health department. Prior to returning to the program, the individual must complete quarantine procedures in coordination with their local health department. We will consult with the Health Department and appropriate action will be taken. This may include recommendation for if/who should be tested and options for testing sites. Families will be made aware through a parent letter and the program will close 1 day for cleaning and sanitizing

In order for families to help us minimize the risk of exposure to COVID-19 we are asking the following:

- Keep children who are sick at home
- Wash/sanitize your hands upon entry to the building and support your child in doing the same
- Follow all precautions from our President, the State of Ohio, Health Department and Center for Disease Control onsite and offsite
- If you or anyone in your household contracts COVID-19 or has suspected contact or exposure let administration know immediately

I understand that with the precautions that I and the CoStars Early Education Services program is taking to minimize the risk of the spread of COVID-19 my child(ren) may be exposed and contract the virus during their normal course of activity (in and out of the childcare setting).

_____	_____
Name of Child	Date of Birth

_____	_____	_____
Name of Responsible Party	Signature of Responsible Party	Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Authorization for Pick Up and Emergency Contacts

Each day when my child is brought to CoStars Early Education Services they will be signed in by an authorized person and left in the care of a staff person.

The individuals listed below are authorized to pick up my child or to assume responsibility for my child in case of an emergency, accident, or illness. If none of the people listed are available, I give permission to CoStars Early Education Services staff to make a plan for the care of my child.

Please list at least 2 people other than parent(s).

Name of Authorized Contact: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of Authorized Contact: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of Authorized Contact: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of Authorized Contact: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please list any information regarding custody arrangements/restraining orders (persons who may not visit or take your child under any circumstances) or indicate if this does not apply by writing N/A on the lines below. Documentation will be needed regarding custody and restraining orders.

_____

_____

_____

_____ _____

Name of Child Date of Birth

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Security Acknowledgement

Best Point Education & Behavioral Health is committed to creating a safe and secure environment for all students, clients, and staff. As a result, the following supports and security measures are in place:

Cincinnati Police Detail Officers
Best Point Education & Behavioral Health contracts with the Cincinnati Police Department to have Detail Officers present during the school day. These officers can be seen walking around campus interacting/participating in program activities with the children and youth, as well as responding to emergency situations.

The detail officers work as part of our team in supporting the success of all children and youth on our campus. The Officers are not employees of Best Point Education & Behavioral Health and must respond to situations as prescribed in their police department protocols.

Our hope is that the presence of the officers will provide a sense of safety and security to all. If at any time you have questions and or concerns, please talk with your child's program administrator.

Metal Detectors
Each building may contain a metal detector which children and youth pass through each day when they arrive on campus. The walk-through detectors, similar to those at an airport, are intended to identify and deter anyone from bringing a weapon into our schools and programs. Hand-held metal detectors may also be used.

**Please note that Early Childhood Day Treatment and Preschool do not use metal detectors on a regular basis.

Security Cameras
Best Point Education & Behavioral Health employs the use of security camera and video and audio taping. The use of the cameras and video and audio taping is to assist in providing for the safety of clients, staff, and facilities at all times. Access to the recordings is restricted to respect the rights and confidentiality of all clients and staff.

The undersigned hereby acknowledges the following:

1. I have been advised of Best Point Education & Behavioral Health's contracting of Cincinnati Police Officers with full police powers, and the use of metal detectors and cameras for security purposes.
2. I have been given a reasonable amount of time to ask questions.
3. I am the legal guardian or legal custodian of the client.

_____	_____
Name of Child	Date of Birth

_____	_____	_____
Name of Responsible Party	Signature of Responsible Party	Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Authorization for Photographic, Cinematic, Voice Reproduction and/or Testimonials

This Authorization is based on the following conditions:

- It is for the above listed Materials only (not any clinical records or other information).
- Materials produced become the property of Best Point Education & Behavioral Health.
- It is given without promise of compensation to you.
- The parent or legal guardian and child/client release to Best Point Education & Behavioral Health any right, title, and/or interest of any kind they may have in the Material produced.
- Granting Authorization to Best Point Education & Behavioral Health is totally voluntary. If you do not grant Authorization, Best Point Education & Behavioral Health will not deny any services or benefits to you/your child.

Authorization to Take, Use, or Disclose Photographic, Cinematic, and/or Voice Reproduction ('Materials')

❑ I **hereby grant** Best Point Education & Behavioral Health the right and authority to photograph, film, interview, and/or vocally record my child.

❑ I **do not grant** Best Point Education & Behavioral Health the right and authority to photograph, film, interview, and/or vocally record my child.

These Materials may then be used by Best Point Education & Behavioral Health for promotional, fundraising, or publicity purposes, and may be used in mass media publications, on the organization's websites and social media sites, televised, or used in film presentations. Media resources include, but are not limited to, newsletters, annual reports, brochures, professional publications, and special event/promotional materials. Unless I check the box, below, my child's and my family's names also may be disclosed. This Authorization is effective for 7 years after my child's last school year or service date at Best Point Education & Behavioral Health, unless revoked in writing by the undersigned. Such revocation can be made at any time, but it will only be effective to prevent further use or disclosure of the Materials. Please note that, once Best Point Education & Behavioral Health discloses or publishes them, the Material could be re-disclosed by a recipient and may no longer be covered by any federal or Ohio privacy laws.

Authorization to Disclose Actual Name(s) in the Activities Listed Above

❑ Best Point Education & Behavioral Health **may** disclose actual name(s) in the activities listed above.

❑ Best Point Education & Behavioral Health **may not** disclose actual name(s) in the activities listed above.

_____ _____

Name of Child Date of Birth

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Field Trip Permission & Release

Please indicate if you grant or refuse permission for your child to attend and participate in these field trips with CoStars Camp-I Can. The field trip schedule is currently tentative. If changes are made to this schedule, a separate permission slip will be given prior to the field trip.

Date	Destination	Departure	Arrival	Consent (Please Circle)
6/9/2022	**Madison Bowl** 4761 Madison Rd Cincinnati, OH 45227	12:00 pm	4:00 pm	YES / NO
6/23/2022	**The Place** 3211 Lina Pl Cincinnati, OH 45239	12:00 pm	4:30 pm	YES / NO
7/14/2022	**Washington Park** 1230 Elm St. Cincinnati, Oh 45202	10:00am	3:30pm	YES / NO
7/28/2022	**Cincinnati Zoo & Botanical Garden** 3400 Vine Street Cincinnati, OH 45220	10:00am	4:00pm	YES / NO

❑ ***I give permission*** for my child to attend and participate in the field trips as specified above. I release Best Point Education & Behavioral Health from any liability for any injury to the child and from any responsibility for the child's conduct while he/she is attending the field trip.

I understand that bus transportation is contracted through First Student Yellow Bus Services (children will walk to Madison Bowl).

My child requires the following special accommodations to fully participate in this field trip:

_____

❑ ***I refuse to grant permission*** for my child to leave the primary Best Point Education & Behavioral Health location to attend the field trips listed above. I understand that all campers and staff will be attending this event and that I must find alternate childcare for my son/daughter.

_____ _____

Name of Child Date of Birth

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Swimming Permission & Release

The pool is located on-site at 5050 Madison Road. Children will participate in swimming activities with their assigned group and supervised by their camp counselors. Our staff to child ratios remain the same during swimming activities:

- For school-age children, the ratio is 1:15. **No more than 26 students may be at the pool at one time.**

Our pool area is staffed with a trained and certified lifeguard, and no groups will participate in swimming activities without a lifeguard on duty. The pool is from 3 to 6 feet in depth. I release Best Point Education & Behavioral Health from any liability for any injury to the child and from any responsibility for the child's conduct while he/she is attending the pool.

Check one:

❑ **I give my child permission** ❑ **I do not give my child permission**
to participate in swimming activities in the pool at Best Point Education & Behavioral Health.

Check one:

❑ **My child has the ability to swim**. ❑ **My child does NOT have the ability to swim.**

_____ _____

Name of Child Date of Birth

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Parent Agreement

Program Specifics

- CoStars Camp-I-Can operates Wednesday, June 1, 2022 – Thursday, August 4, 2022, from 7:30 am - 5:30 pm, Monday-Friday. Closed on Monday, July 4th.
- If the program is closed or delayed due to inclement weather notification will be provided on the local news channels listed as **CoStars Camp-I-Can**.
- Parents are advised that students may be participating with the Camp-I-Can program to fulfill college course requirements by observing their child and/or participating in their child's classroom activities.
- All forms must be completed and returned to the program prior to the child's attendance.

Arrival and Departure

- Children must arrive prior to 9:30am.
- Children must be signed in and out each day by a parent or authorized adult. If someone other than the parent is picking up, you must notify the Front Desk or the child's teacher.
- Children must be picked up no later than close of program.

Fees

Weekly Tuition:

Tuition Rate	**$200 / week**
Employee Rate	**$100 / week**
Hamilton County Voucher	**Weekly Copay (Set by HCJFS)**

Payments

- Tuition is due by close of business on Fridays for the upcoming week of attendance. The program reserves the right to withdraw your child(ren) after 1 week of non-payment of tuition or if the account becomes delinquent.
- Payments are processed through ProCare, our electronic payment service. You will receive a link to download and set up the ProCare app to make payments. Automatic payments are available! Payments can be automatically withdrawn after you complete an authorization form. If necessary, cash, checks, and money orders are acceptable forms of payment. **Please note that when paying with cash, we cannot give out change.**
- **If you wish to set up an alternative payment schedule, please contact Sue Leach in Accounts Receivable at 513-272-6476.**
- The parent or guardian whose name is on the billing record is ultimately and solely responsible for paying the balance due.
- Returned check fee is $30.
- Failure to pick up a child by close of program will result in a charge of $5 for the first six minutes and $3 per every 5-minute increment after that. Repeat late pick up may result in suspension or termination from program.
- Fees will not be waived for absences, including those due to illness, vacation, or program closings.
- Parents may voluntarily withdraw their child from the program by giving a minimum three-day written notice. If notification is not received, a one-week tuition fee will be assessed to the parent's account and will be due immediately.

Hamilton County Child Care Voucher Program

- Full time students must attend at least 25.00 hours per week; if necessary, an absence will be used to meet hours.
- May not exceed 10 absences per 6 months (Jan.-June, July-Dec.). Absences incurred from January-June with your previous provider will carry over. Additional absences will result in the assessment of additional fees on the account, which will be due immediately. Parents are ultimately responsible for payments. This includes but is not limited to co-pay discrepancies, authorization issues, re-eligibility delays, late voucher payments, and unauthorized days due to eligibility restrictions. Failure to do so may result in suspension and/or termination from the program.
- Parents must have voucher coverage on the 1st day of care. A self-pay fee will be billed until coverage is received. Billings will be adjusted only once voucher coverage is provided and back swipes have been completed for all days attended.
- Parents must use the TAP system to sign children in and out daily. This is a condition of HCJFS' childcare coverage; failure to do so may result in HCJFS terminating childcare voucher coverage. (NOTE: no staff member can complete swipes, per HCJFS' policy.)
- Attendance must be completed by the "settlement deadline" date (two weeks from attendance date) a chargeback will be assessed at the family's expense. If payment is not received from HCJFS due to incomplete attendance, the tuition becomes the parents' responsibility as self-pay and an additional charge will be placed on the account for the dates effected.

- In the event of an unpaid balance, the program reserves the right to file a delinquent voucher form with HCJFS.

I understand and agree to abide by the written policies set forth in the parent handbook. I understand that it is my responsibility to contact the Program Supervisor with any questions I have about the information contained in this document.

I have read and understand the information above. I understand my rights and responsibilities regarding the attendance requirements. I further understand my financial obligations.

I have received a copy of and am familiar with the policies and procedures outlined in the parent handbook.

_____	_____
Name of Child	Date of Birth

_____	_____	_____
Name of Responsible Party	Signature of Responsible Party	Date

* Responsible Party is parent or guardian, or client if 18 years of age or over, or an emancipated minor

Ohio Department of Education - Office for Child Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

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

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

Instructions for Completion

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

CENTER NAME

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

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

Check (✓) Days Child Normally in Care		**List Hours Child Normally in Care**				**Check (✓) Meals Child Normally Receives while in Care**					
		Arrive	**Depart**	**Arrive**	**Depart**	**Breakfast**	**AM Snack**	**Lunch**	**PM Snack**	**Supper**	**Evening Snack**
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

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

SIGNATURE OF PARENT/GUARDIAN	**DATE**	**DAY PHONE NUMBER**

MAILING ADDRESS:
STREET /APT. **CITY** **ZIP CODE**

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:
(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
(2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider. (rev. 12/3/2015)

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2021-2022

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

CENTER NAME _____

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

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

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

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

CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __
CASE NO.	__ __ __ __ __ __ __

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

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

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

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

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

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

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

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

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

State Distribution: July 2021

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

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

Application Certified/Categorized as:

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

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

Total Household Size: _____

Total Household Income: $_____

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

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

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

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

HOUSEHOLD LETTER - Dear Parent or Guardian

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL

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

NON-DISCRIMINATION STATEMENT: In accordance with Federal civil rights law and 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: How to File a Complaint, 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: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

REDUCED INCOME ELIGIBILITY GUIDELINES

Guidelines to be effective from July 1, 2021 through June 30, 2022. Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	23,828	1,986	993	917	459
2	32,227	2,686	1,343	1,240	620
3	40,626	3,386	1,693	1,563	782
4	49,025	4,086	2,043	1,886	943
5	57,424	4,786	2,393	2,209	1,105
6	65,823	5,486	2,743	2,532	1,266
7	74,222	6,186	3,093	2,855	1,428
8	82,621	6,886	3,443	3,178	1,589
For each additional family member, add	+8,399	+700	+350	+324	+162

ODJFS TANF non-assistance Eligibility Form for TANF Funded Services

This Application is to be completed by the applicant/participant who is a parent of a minor child age 17 or younger, or 18 and in high school.

Name:	Social Security#:		Phone Number:
Street Address:	City:	State:	Zip Code:

Step 1: Citizenship/Qualified Non-citizenship Status
Citizenship or qualified non-citizenship status is required for "means tested benefits." This means eligibility for the benefit, program or supportive service is based on income. If the applicant does not meet one of the following status criteria, (s)he is considered **not** eligible for TANF "means tested benefits."

1. Is the applicant/individual/family member a United States Citizen? ☐ YES ☐NO

2. Does the applicant meet one of the Citizenship exceptions under Ohio Administrative Code 5101:1-2-30
   ☐ YES ☐ NO

If yes, please indicate which exception and date of entry: Click here to enter text.

Step 2: Family Household and Income

The family requesting service includes a parent or relative of a dependent child under 18 (or under 19 who is still a full-time student in high school or at the equivalent level of vocation or technical training), who has never been married, and the child lives in the home.

Using the chart below, determine if the household income is at or below 200% of the 2018 Federal Poverty Level limits. Select the applicable household family size and monthly income that matches the income status for the applicant family.

Household Family Size (include mom, and dad/ legal guardian and children)	Monthly household income is below this amount	☑	Household Family Size (include mom, and dad/ legal guardian and children)	Monthly household income is below this amount	☑	Household Family Size (include mom, and dad/ legal guardian and children)	Monthly household income is below this amount	☑
1	$2,082		4	$4,292		7	$6,502	
2	$2,819		5	$5,029		8	$7,239	
3	$3,555		6	$5,765		9	$7,975	

Number of household members: Click here to enter text.

Is the family's total income at or below 200% of the Federal Poverty Level based on household size? ☐ Yes ☐ No

Complete the chart with all minor children of the applicant

Name	Age	Name	Age

Step 3: Self Attestation

The Provider is to review the following statements with the program applicant/participant

☐ I understand that I am required by law to provide my social security number to receive TANF funded benefits/services. This is mandatory under the Social Security Act (42 U.S.C. 1137.)

☐ I understand that my Social Security Number will be used to associate all records to my identification including program participation and the receipt of services and benefits.

☐ I certify to the best of my knowledge, the information included in this application is true, including income and citizenship/qualified non-citizenship information.

☐ I certify that as the parent or legal guardian of the minor child for whom service is being request, we have not fraudulently received benefits under the OWF and/or PRC programs, OR that we have repaid the cost of any fraudulent assistance as defined in section 5101.83 Revised Code and rule 5101:1-23-75 of the Ohio Administrative Code.

Name: _____ Social Security#: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Signature **Date**

HOW DO I FILE A DISCRIMINATION COMPLAINT?
Your complaint can be filed with:
The Ohio Department of Job and Family Services
Bureau of Civil Rights
30 East Broad Street, 37th Floor
Columbus, Ohio 43215-3414 Fax to: (614) 752 – 6381

The Bureau of Civil Rights (BCR) staff is available to offer assistance with writing and filing your complaint(s). You can call BCR at (614) 644-2703 or Toll Free 1-866-227-6353, TTY (614) 995-9961 or Toll Free 1- 866-221-6700.