On or before your child's first day of attendance we will need:

___Enrollment Application

___Completed emergency contact information form

___Financial Agreement and Payment Policy

Form (signed by both parents if applicable)

___Family Handbook Agreement

___Signed Permission Forms

___General Health Appraisal Form signed by physician

___Current records of immunization

___Allergy, Asthma, and Special Health Conditions

___Health Care Plan, if required

___USDA Income Eligibility Form

___Door Access Badge completed and turned into Susan

Your $50.00 registration fee and tuition for the first month/remainder of the month paid by credit card on the website
https://commerce.cashnet.com/rrcccdcpay

Children's Center @ Red Rocks Community College 303-914-6328

APPLICATION FOR ENROLLMENT

Date of Enrollment _____ Date of termination _____

Child's Name_____Nickname_____

Birth Date_____Place of Birth_____Gender_____
Phone_____Child lives with_____
Relationship to child_____
Address_____City_____State_____Zip_____
Does your child have medical insurance?_____ Documented vision screening?_____ Documented hearing screening? _____ Documented dental screening? _____ Do you need resources on how to obtain medical insurance?_____
Name and phone of child's primary care provider _____

Family Member #1_____Relationship to child_____
___Parent___Step Parent____Legal Guardian____Temporary Guardian_____Other_____Joint Custody_____Not Joint Custody
Address_____City_____State_____Zip_____
Home Phone_____Work_____Cellular_____
Pager_____ email _____
Social Security #_____Driver's license #_____
Employer_____Occupation_____
Address _____

If we cannot immediately contact you at work, who could find you:
Name_____Phone #_____
Employer Address_____City_____State_____Zip_____

Family Member #2_____Relationship to Child_____
___Parent___Step Parent____Legal Guardian____Temporary Guardian____Other_____Joint Custody_____Not Joint Custody
Address_____City_____State____Zip_____
Home Phone_____Work_____Cell_____
Pager_____ email_____
Social Security #_____Drivers License #_____
Employer_____Occupation_____
Address _____

If we cannot immediately contact you at work, who could find you:
Name_____Phone #_____
Employer Address_____City_____State____Zip_____

Are there legal restrictions on who can have contact with your child? ___No __Yes
If yes, please list and submit legal papers.
Persons Name_____Relationship to child_____
Photo on file? ____No ____Yes

Other's living in home:
First & Last Names_____Age___Relationship to child_____

First & Last Names_____Age___Relationship to child_____
First & Last Names_____Age___Relationship to child_____
First & Last Names_____Age___Relationship to child_____
Ethnic Information for use in writing grant proposals:

What language is spoken in the home?_____

Check one: ☐ Alaskan Native/American Indian ☐ Asian/Pacific Islander ☐ Black, not Hispanic ☐ Hispanic ☐ White

People who may be called in an emergency and who are authorized to take your child from our Center. We cannot release your child to anyone NOT on the list, other than parents/guardians. Please indicate who to call first in an emergency.

Name #1_____Relationship to Child_____
Address _____ Phone # _____

Name #2_____Relationship to Child_____
Address _____Phone # _____

Name # 3 _____ Relationship to child _____
Address _____ _____Phone # _____

Health Care Practitioner Name _____Phone _____

Dentist's Name _____Phone _____

Preferred hospital _____

Address _____ Phone_____

We understand it is our responsibility to inform the Children's Center @ Red Rocks Community College any time the above information changes. We also understand that the center will attempt to reach one of the people on this form, trying to reach us as parents/guardians first, if there is an emergency, before any action is taken. In the event that we cannot be reached, the staff has our permission to use discretion in securing medical aid. We give permission for emergency medical or hospital personnel to perform the necessary care needed for our child during an emergency. We further understand that the Children's Center @ RRCC, the staff at the Children's Center @RRCC, Red Rocks Community College, the staff at Red Rocks Community College and/or any person responsible for obtaining medical aid for our child will not be responsible for any expense incurred by our family due to medical aid being given to our child.

Parent/Guardian #1 Signature_____
Date_____
Parent/Guardian #2 Signature_____
Date_____

A $50.00 non-refundable registration fee is due with this application.

CHILDREN'S CENTER @RED ROCKS --EMERGENCY INFORMATION

Child's Name: _____Birthdate: _____

Legal Guardian # 1 Name: _____
Telephone Numbers: Home _____Work _____

Legal Guardian #2 Name: _____ _____
Telephone Number Home: _____Work _____ _____

Emergency Contacts (to whom child may be released if legal guardian is unavailable)
Name # 1 _____
Address: _____
Telephone Numbers: Home _____ Work _____
Name # 2 _____
Address: _____
Telephone Numbers: Home _____ Work _____

Child's Usual Source of Medical Care

Name _____
Address: _____
Telephone Number _____

Child's Usual Source of Dental Care

Name: _____
Address: _____ _____
Telephone Number _____

Child's Health Insurance
Name of Insurance Plan: _____ID # _____
Subscriber's Name (on insurance card): _____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations
_____
_____

Transport Arrangements in an Emergency Situation

Ambulance service _____Child will be taken to: _____
(Parents/guardians are responsible for all emergency transportation charges)

Parents/Legal Guardian Consent and Agreement for Emergencies

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed to **act on my behalf** until I am available I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: _____ Parent/Legal Guardian's Signature # 1 _____

Date: _____ Parent/Legal Guardian's Signature #2 _____

FAMILY HANDBOOK AGREEMENT

I HAVE READ AND UNDERSTAND THAT OUR FAMILY WILL FOLLOW THE PRACTICES AND POLICIES SET FORTH IN THE MOST CURRENT FAMILY HANDBOOK FOR THE CHILDREN'S CENTER AT RED ROCKS COMMUNITY COLLEGE. I KNOW IF I HAVE QUESTIONS THAT I AM TO CONTACT THE DIRECTOR OF THE CENTER FOR ANSWERS TO MY QUESTIONS.

Parent/Guardian #1 _____Date _____

Parent/Guardian #2 _____Date _____

FINANCIAL AGREEMENT AND PAYMENT POLICIES

- **Payment is due for the month of care of the first of each month. A late fee of $25.00 will be assessed on the 10th of the month if tuition has not been paid.**
- **Check:** Make checks payable to The Children's Center.
- **Credit Card:** All credit card payments (preferred method) are made on line at https://commerce.cashnet.com/rrcccdcpay. Responsible party must log in **the first attendance day of each month to make payment.**
- **Cash:** Cash payment must be made at college cashiers dept. Please pick up a Miscellaneous Deposit Form to take with your payment.
- Tuition is based on contracted days, not on actual days of attendance.
- **Payment is due for enrolled days whether child attends or not. We cannot substitute attendance days if your child does not attend on his/her scheduled days of attendance.**
- There is a non-refundable $50.00 registration fee per child due at time of registration and each August. A portion of this fee pays for the on line assessment program used to track each child's development. Families who enroll after May 31 will not be charged the annual fee until the following year.
- Holidays and in-service days are fee days. Families are not charged for 1 week of closure in Aug. and 1week of closure in Dec. Tuition is calculated multiplying weekly rate x 50 weeks /12 months and rate is consistent each month.
- Childcare may be denied for any child for whom tuition is more than 2 weeks late.
- Accounts are subject to a $25.00 processing fee for returned check or denied card.
- Late pick up fee is $1.00 per minute after 6pm. Consideration is made for weather conditions and circumstances.
- Vacations-full payment is due for 2 consecutive weeks of vacation, and 50% for additional consecutive weeks, if written notice of vacation is provided.
- Parent fees for families receiving CCCAP assistance must be paid in full on the first attendance day of each month.

I understand the monthly fee for my child is _____and I have read and agree to the financial policies outlined in the Family Handbook and above.

Signature_____ Date_____

Signature_____ Date_____

The Children's Center @ RRCC Permission Requests

Topical Preparations (Preventive)

Please check all of the permissions that you agree to. If you do not wish to grant permission for any of the permissions below, please indicate NO and discuss with the director.

Child's Name_____

Sunscreen: I give permission for the staff of The Children's Center @ RRCC to apply sunscreen to my child's exposed skin. I understand that it is my responsibility to apply sunscreen to my child in the morning prior to or upon arrival. The staff will reapply sunscreen in the afternoon.

_____ I will provide sunscreen for my child, labeled with first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

_____ I authorize the use of SPF RX, Mineral Sunscreen SPF 40 on my child.

Lotion/Lip Balm

_____ I will provide a fragrance-free lotion and/or lip balm, labeled with my child's first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

_____ I authorize the staff to use fragrance-free moisturizing lotion on my child.

Diaper Ointment/Cream

_____ I authorize the staff of The Children's Center @ RRCC to apply diaper rash ointment/cream to my child, in the original container, labeled with my child's full name and with the noted expiration date and I will replace prior to expiration. I understand that I may only provide diaper rash ointment/cream, free of antibiotic, antifungal or anti-inflammatory components **without a written prescription from my doctor.**

I agree to the use of the products mentioned above and understand that I must check the ingredients of all products to ensure that my child is not allergic to them. I understand that skin lotion/cream/balm will not be applied to broken skin or if a skin reaction has been observed. Parent will be informed of skin reaction promptly.

_____ _____

Parent Signature Date

The Children's Center @ RRCC Permission Requests

Child's Name _____

College students working with children The Children's Center is a lab site for students. Students may do observations and activities with children in The Children's Center for educational/training purposes. These students have completed background checks and are always supervised by staff.

_____ I give permission for my child to be observed and participate in activities with the Early Childhood Education students at the college.

Photo/Video Use Photos/videos taken of children in the classroom are often appropriate for staff and training in Early Childhood Education classes, as well as other classes such as Psychology. Videos and photos will never be used for commercial purposes.

_____ I give permission for my child's picture to be used for the above purposes.

Walks on college campus Children may take walks with the staff on the college campus, both indoors and out. If children were to cross streets, the walk would be considered a field trip and a special permission form would be requested, prior to the walk.

_____ I give permission for my child to take walks with the staff on college campus indoors and outdoors.

Media Use On rare occasions, a teacher may select a video to enhance topics that the children are investigating.

_____ I give permission for the staff to use video to enhance a topic the children are learning about.

Use of Cots For Rest Permission must be granted for chidren under the age of two to rest on a cot.

_____ I give permission for my child to lay on a cot during rest time.

_____ _____

Parent Signature Date

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name:_____ **Birthdate:** _____

Allergies: ☐ None or Describe_____

Type of Reaction _____

Diet: ☐ **Breast Fed** ☐ **Formula** _____ ☐ **Age Appropriate**

☐ **Special Diet** _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

☐ **Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, _____ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: n/a_____ **DATE:** _____

Parent/Guardian Signature_____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ **Weight @ Exam:** _____

Physical Exam: ☐ **Normal** ☐ **Abnormal** (Specify any physical abnormalities)_____

Allergies: ☐ None or Describe_____ Type of Reaction _____

Significant Health Concerns: ☐ Severe Allergies ☐ Reactive Airway Disease ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Hospitalizations ☐ Developmental Delays ☐ Behavior Concerns ☐ Vision ☐ Hearing ☐ Dental ☐ Nutrition ☐ Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: ☐ None or Describe _____

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

☐ Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

OR ☐ Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: ☐ Up-to-Date ☐ See attached immunization record ☐ Administered today: _____

Health Care Provider: Complete if Appropriate

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _____ ****

**** HCT/HGB _____ ** Lead Level ❑Not at risk or Level _____**

****TB ❑Not at risk or Test Results** ❑ Normal ❑ Abnormal

****Screenings Performed: ❑Vision:** ❑Normal ❑Abnormal **❑Hearing:** ❑Normal ❑Abnormal **❑Dental:** ❑Normal ❑Abnormal-

Recommended Follow-up_____

Provider Signature

Next Well Visit: ☐ Per AAP guidelines* or ☐ Age_____

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

_____

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp

Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

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COLORADO
Department of Public Health & Environment

Child Care Immunization Chart

Vaccines Required for Child Care, Preschool & K-Entry 2022-2023

1. This chart is a "guide" for childcare providers to determine which vaccines children are required to have in order to be in compliance with state immunization requirements. Select the appropriate age range for the student from the left hand column. The number of required doses is located in each of the columns and vaccines are listed across the top of the page. Review the student's immunization record with this chart to make sure they have at least the number of doses required. The Colorado Board of Health has accepted the Advisory Committee on Immunization Practices (ACIP) schedule for those immunizations already "required" for attendance. Vaccines that are not required but recommended include: Rotavirus, Hepatitis A and Influenza vaccines.
2. Please follow the ACIP Immunization Schedule, Table 1, Table 2 and Notes, for specific guidance at: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf.
3. If the student does not have the minimum number of doses, the parent/guardian is to be directly notified (in person, by phone, or by mail) that their child does not have the required minimum number of vaccine doses. Within 14 days of direct notification from the child care, the parent/guardian is to obtain the required vaccine(s). Parents are to provide a written plan for remaining vaccines following the ACIP Immunization Schedule.
4. Colorado law allows for a Certificate of Medical Exemption to be signed by a healthcare provider and submitted once, unless the student's information or school changes. A Certificate of Nonmedical Exemption is to be submitted by a parent/guardian who chooses to exempt at 2 months, 4 months, 6 months, 12 months and 18 months of age. Parents and schools can access medical and nonmedical exemption guidance at www.colorado.gov/vaccineexemption.

Age of Child	# of required doses **DTaP** *Diphtheria, Tetanus and Pertussis*	# of required doses **IPV** *Polio*	# of required doses **MMR** *Measles, Mumps and Rubella*	# of required doses **Hib** *Haemophilus influenzae* type b	# of required doses **Hep B** *Hepatitis B*	# of required doses **Varicella** *Chickenpox*	# of required doses **PCV13** *Pneumococcal Disease*
By 1 mo.	-	-	-	-	1✍	-	-
By 3 mos.	1	1	-	1	2✍	-	1~
By 5 mos.	2	2	-	2	2✍	-	2~
By 7 mos.	3	2	-	3/2♥	2✍	-	3/2~
By 16 mos.	3	2	1+	4/3/2/1♥	2✍	1*	4/3/2~
By 19 mos.	4	3	1	4/3/2/1♥	3✍	1	4/3/2~
By 2 years	4	3	1	4/3/2/1♥	3✍	1	4/3/2/1~
By K Entry	5/4♦	4/3♣	2		3✍	2	-

♦ Five doses of DTaP vaccines are required at school entry in Colorado unless the 4th dose was given at 48 months of age or older (i.e., on or after the 4th birthday) in which case only 4 doses are required. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3, at least 4 months between dose 3 and dose 4, and at least 6 months between dose 4 and dose 5. The final dose must be given no sooner than 4 years of age (dose 4 may be given at 12 months of age provided there is at least 4 months between dose 3 and dose 4).

♣ Four doses of Polio vaccine are required at school entry in Colorado. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3, and at least 6 months between dose 3 and dose 4. The final dose must be given no earlier than 4 years of age. A 4th dose is not required if the 3rd dose was administered at age 4 years or older and at least 6 months after the 2nd dose.

\+ The first dose of MMR vaccine given more than 4 days before the 1st birthday is not a valid dose and cannot be accepted. ACIP recommends that the 1st dose of MMR be given between 12 -15 months of age. The student is out of compliance if there is no record of MMR at 16 months of age.

♥ The number of Hib doses required depends on the child's current age and the age when the Hib vaccine was administered. If any dose is given at or over 15 months, the Hib requirement is met. For children who begin the series before 12 months, 3 doses are required, of which at least 1 dose must be administered at, or over, 12 months. If the 1st dose was given at 12 to 14 months, 2 doses are required. If the student's current age is 5 years or older, no new or additional doses are required. The number of doses and the intervals may vary depending on the type of Hib vaccine.

✍ The Hepatitis B vaccine is the only immunization that can be given as a birth dose. The 2nd dose to be given by 3 mos of age & the 3rd dose is to be given by 19 months of age. Minimum intervals between doses must be followed if a student is on a catch-up schedule: at least 4 weeks between dose 1 and 2, 8 weeks between dose 2 and 3 and 16 weeks between dose 1 and 3. The final dose must be given no earlier than 24 weeks of age. 4 doses of Hepatitis B vaccine are permitted when a combination vaccine is used.

* If a child has had chickenpox disease and it is documented by a healthcare provider, that child has met the Varicella requirement. Varicella given more than 4 days before the 1st birthday is not a valid dose and cannot be accepted. ACIP recommends a 1st dose between 12 – 15 months. The student is out of compliance if the 1st dose is not given by 16 months of age.

~ The number of doses of PCV13 depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered between 2 to 6 months of age, the student will receive 3 doses (2, 4 & 6 months of age) at least 4 -8 weeks apart, and a booster dose between 12 – 15 months, at least 8 weeks after the last dose. If started between 7 to 11 months of age, the student will receive 2 doses, at least 8 weeks apart, and a booster dose between 12 to 15 months of age. If the 1st dose was given between 12 to 23 months of age, 2 doses, at least 8 weeks apart, are required. Any dose given at 24 months through 4 years of age, the PCV vaccine requirement is met. No doses are required once the student turns 5 years of age.

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: ..... **Date of birth:** .....

Parent/guardian: .....

Required Vaccines

	Immunization date(s) MM/DD/YY						**Titer Date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer Date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Health care provider Signature or Stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

ATTENTION PARENTS/GUARDIANS

This letter is to ensure that your child has his/her proper medical forms which will support our program in providing a healthy and safe environment for your child.

- Children needing any medication during program hours require **medication authorization(s)** that are signed by your health care provider.
- Children with **severe allergies** requiring medication are required to have a completed health care plan that is signed by your health care provider.
- Children with **asthma** that regularly require asthma medication during program hours are required to have a completed asthma health care plan that is signed by your health care provider.
- Children with **special health conditions** are required to have a completed health care plan signed by your health care provider. This plan will be individually designed for your child; as delegated by the program's nurse consultant, the program staff and the child's guardian(s).

_____

To Be Completed and Returned By Parent/Guardian

- Does your child have any food exclusions due to an allergic reaction to the food? YES ☐ NO
  if yes, please list food and your child's reaction to exposure:

Food	Reaction	Medication
_____	_____	_____
_____	_____	_____

- Does your child have any other allergies requiring medications or special attention? ☐ YES ☐ NO

- Does your child have a special health condition (such as seizures, diabetes, feeding tube, oxygen, etc.) that requires special attention by center staff?

If yes to any of the above, please circle the appropriate response below:

- I will provide a Health Care Plan signed by my child's health care provider.
- I understand that the nurse consultant will review the health care plan and is available to assist in this process.
- I do not want a HCP for my child at this time.
- Please do not serve these foods to my child at this time.

Child's Name_____ Birthdate_____

Parent's Signature_____ Date_____

RRCC Children's Center Door Access Badge
Parent Contact Information

Child's Name 1: _____

Child's Name 2: _____

Parent 1 Name: _____

Phone Number: _____ Work Number: _____

Email Address: _____

Parent 2 Name: _____

Phone Number: _____ Work Number: _____

Email Address: _____

Other Authorized Adult: _____

Phone Number: _____

Email Address: _____

Parents/Other Adults are responsible for keeping track of their access badges. If you lose your badge, please contact Campus Police immediately at 303-914-6394 so that we can deactivate your badge and schedule a time to get you a new one. The initial cost for your first badge is $10/badge. The cost to replace a lost badge is $10.00. The fees can be paid at the cashier's

RRCC Emergency Alert Messaging

In the event of a campus closure due to weather or an emergency due to an imminent threat, you will be notified immediately. In order to OPT IN to RRCC Emergency Alert text message notifications please check the box below and provide the mobile number(s) that you would like the text messages to be sent to. If you need to update your phone number or OPT OUT please contact the Police Services Manager via email at loretta.tafoya@rrcc.edu

☐ OPT IN to Text Messaging Emergency Alert Notifications
Mobile Number(s): _____

You will automatically be subscribed to email and voice call alerts with the email address and phone number(s) that we have on file.

Parent 1 Signature: _____ Date: _____

Parent 2 Signature: _____ Date: _____

Other Adult Signature: _____ Date: _____

CC Director Signature: _____ Date: _____

VP Signature Approval: _____ Date: _____

Internal Use Only

Initials of Person Processing Badge: _____ Time: _____ Date Processed: _____

Signature of PSM: _____ Date Received by PSM: _____

COLORADO
Department of Public Health & Environment

2023-2024 Income Eligibility Form (IEF) for Child Care

STEP 1: List ALL children in day care

Children in Foster care or Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Review the Dear Parent Letter for more details. If there are more than three children, please complete an additional form.

			Check all that apply				
Child's First Name	**Child's Last Name**	**Age**	**Foster Child**	**Migrant**	**Runaway**	**Homeless**	**Head Start**

STEP 2: Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF YES → Write the case number here & proceed to STEP 4 (Do not complete STEP 3) **CASE NUMBER:** _____ (Write only one case number in this space.)
IF NO → Go to STEP 3

STEP 3: Report Income for ALL Household Members (Skip this step if you answered Yes to Step 2)

Flip the page for information on sources of income for child income and Household Members.

A. Child Income
Sometimes children in the household earn or receive income.
Please include the TOTAL income received by any children listed in STEP 1.

B. All other Household Members (including yourself)
List other household members not listed in STEP 1 (include yourself) even if they do not receive income. For each household member listed, if they do not receive income, report total gross income (before taxes) for each source in whole dollars (no cents**). If they do not receive income from any source, write '0'. If you enter '0', you are certifying that there is no income to report.**

Child Income:		**Circle one:** Yearly Monthly Bi-weekly Weekly

Name of other Household Members (First and Last Names)	Earnings from Work	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)	Welfare/ Child Support/ Alimony	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)	Pensions/ Retirement/ Social Security/SSI/VA Benefits	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)
	$		$		$	
	$		$		$	
	$		$		$	

Total household Members (Children and Adults)		Last Four Digits of Social Security Number (SSN) of primary wage earner or other adult household member.	**XXX-XX-**	Check if no SSN	

STEP 4: Contact Information and Adult Signature

"I certify 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 that information. I am aware that is I purposely give false information, the participant/center may lose meal benefits and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form	Signature of Adult	Today's Date
Address	City, State, Zip	Phone/Email

COLORADO
Department of Public Health & Environment

2023-2024 Income Eligibility Form (IEF) for Child Care

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages.
Social Security • Disability Payments • Survivors Benefits	A child is blind or disabled and receives Social Security benefits. A parent is disabled, retired or deceased, and their child receives Social Security benefits.
Income from person outside of household	A friend or extended family member regularly gives a child spending money.
Income from any other source	A child receives regular income from a private pension fund, annuity or trust.

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
Salary, wages or cash bonuses Net income from self-employment (farm or business) If you are in the U.S. Military Basic pay and cash bonuses (DO NOT include combat pay, FSSA or privatized housing allowances) Allowances for off-base housing, food and clothing	Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits	Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household

STEP 5: Children's Ethnic and Racial Identities

We are required to ask for information about your children's race and ethnicity. Responding does not affect your children's eligibility for receiving meals during care. Check all boxes that apply to the child(ren) in care.

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White (Includes Hispanic and Latino) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native

Nondiscrimination Statement Revised May 2022

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at 202-720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at 800-877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online, from any USDA office, by calling 866-632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: Mail: US Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: program.intake@usda.gov This institution is an equal opportunity provider.

For center staff use only

Annual Income Conversion: Weekly x 52, Biweekly x 26, Monthly x 12

Household Last Name:	

Total Income	**$**	**How Often?** (Circle One)	Yearly Monthly Bi-Weekly Weekly	**Household size:**		**Eligibility**	**Free**	**Reduced**	**Paid**

Determining Official's Signature Month/Year Expiration Date* (Month/Year) Today's Date

*This form expires 12 months after the month in which the institution makes the determination.

Example: If the determination is **July 2023, the form is valid from July 1, 2023 through July 31, 2024.** The institution may use the date the participant/guardian signs the Income Eligibility Form **OR** the date the institution's official make the determination and signs the Income Eligibility Form. The same approval method selected must be used for all forms approved by the institution.

Revised 04/2023