

A Leap of Faith CDC/Redding Full Day Preschool

1715 West 4th Street Wilmington, DE 19805
Phone: (302) 543--6256 Email: aleapoffaith68@yahoo.com

Application Date: _____

Please mark all that applies: Redding Preschool _____ POC _____ Tuition _____

Income Verified Current Tuition/Non-POC

ALOF Acceptance Date _____ Enrollment Date _____

Please check to reassure that all applicable documents below are included with your application:

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Authorization to Release
<input type="checkbox"/> IEP (if applicable)	<input type="checkbox"/> Television & Video Viewing
<input type="checkbox"/> Custody Consent Form (if applicable)	<input type="checkbox"/> Photography Release
<input type="checkbox"/> Proof of Income i.e., 2 pay stubs/TANF	<input type="checkbox"/> Computer Usage
<input type="checkbox"/> Current Medical Insurance Card	<input type="checkbox"/> Field Trip Permission
<input type="checkbox"/> Physical Form w/Lead/ Hemoglobin/HCT	<input type="checkbox"/> Program Screening form
<input type="checkbox"/> Dental Form or appt. card	<input type="checkbox"/> CACFP form
<input type="checkbox"/> Emergency Contact Sheet	

STUDENT INFORMATION

Date of Birth _____

Name: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Parent Email Address: _____

Has child attended childcare in the last two years? Yes No

If yes please list the name(s): _____

Briefly explain your reason for transition to our program. _____

PARENT INFORMATION

Primary Caretaker(s)

Date of Birth _____

Name: _____ Relationship to Child: _____
(First) (Middle) (Last)

Place of employment/name of school: _____

Work/Daytime Phone: _____ Cell Phone: _____ Evening Phone _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced

Is there a secondary Caretaker (i.e., non-custodial parent, grandparent in home)? ___ Yes ___ No

Name: _____ Relationship to Child: _____
(First) (Middle) (Last)

Place of employment/name of school: _____

Work/Daytime Phone: _____ Cell Phone: _____ Evening Phone _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced

Non-Custodial parent information:

Date of Birth _____

Name: _____ E-mail: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Primary Caregiver Questions

Are you a teen parent? Yes No

Highest level of school completed:

Grade 11 or less High School Associates Bachelors Masters

Work/Daytime Phone: _____ Cell Phone: _____ Evening Phone _____

How did you hear about our program?

Flyer social media Website Search Pamphlet Referring Agency

Employee: _____ Other: _____

INCOME INFORMATION

*A household consists of the child you are applying for, any adult caretakers for that child, and the siblings of that child who all reside in the same home

Total Number in Household*: _____ Income Amount: _____

Number of children in Household*: _____ Number of Adults in household*: _____

Frequency of Income: ____ Weekly ____ Bi-Weekly ____ Monthly ____ Yearly

Employed: Full-time Part-time School or Training Retired or Disabled
 Unemployed

Source of Income: ____ Wages ____ Social Security ____ TANF
____ Child Support ____ Unemployment ____ Other (specify)

Evidence of Income ____ Payroll Stubs (2) ____ Previous year's taxes ____ W-2 Forms
____ S.S. Award Letter ____ TANF Documents ____ Other (specify)
____ Foster Care Document ____ Unemployment Compensation

Did you previously receive State Purchase of Care for childcare expenses? ____ Yes ____ No

I/we certify that the above is true to the best of my /our knowledge. I understand that purposeful misrepresentation of information will result in the rejection of my application.

(Parent/Guardian)

(Date)

(Parent/Guardian)

(Date)

ALOF CDC does not discriminate based on race, color, national origin, sex, age, or handicap. Title 16, Chapter 9, Sections 901 to 909 requires that ALOF staff report all sexual abuse, child abuse, and/or neglect to the Division of Child Protective Services. Rev. 01/09

DENTAL VISIT FORM

NAME: _____

DATE OF BIRTH: _____

DATE OF VISIT: _____

SCHEDULED SERVICE (check all that apply):

Oral Examination

filling

Cleaning

extraction (temporary)

Fluoride

extraction (permanent)

x-ray

root canal

sealant

Other: _____

THIS CHILD WILL NEED MORE VISITS FOR THE FOLLOWING SERVICES (check all that apply):

oral examination

filling

cleaning

extraction (temporary)

fluoride

extraction (permanent)

x-ray

root canal

sealant

Other: _____

Comments:

Examiner's Signature: _____

Date: _____

Printed Name: _____

Phone: _____

Address: _____

Alternate Phone: _____ Alternate Phone: _____

Medical Insurance Information:

Name of Company: _____

Subscriber Name: _____

Policy Number: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Emergency Contact Sheet

Child Name _____

Parent/Guardian Information

Name _____

Name _____

Address _____

Address _____

Daytime Phone _____

Daytime Phone _____

Evening Phone _____

Evening Phone _____

Alternate Phone _____

Alternate Phone _____

Alternate Phone _____

Alternate Phone _____

If a parent/guardian cannot be contacted, please contact the following person(s) in case of emergency:

Full Name	Phone Number(s)	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child Physician: _____ Phone: _____

Child Dentist: _____ Phone: _____

List any health problems or allergies: _____

Signature: _____ Date: _____

Authorization of Release Form

Child Name _____

This form authorizes ALOF staff to release your child for pick-up to people listed below:

Full Name	Relationship to Child
_____	_____
_____	_____
_____	_____
_____	_____

Picture identification is necessary for authorized people to pick up your child. This list should be updated as necessary. Please inform the Teacher or the office of any changes. If someone other than the people listed above arrives to pick up your child, ALOF staff will not release the child into their care without first contacting you. ***Please note that children will not be released to anyone who is under the influence of alcohol or drugs, or who displays inappropriate behavior, regardless to whether they are listed on this form.***

Please list phone number where you can be reached in the event of a pick-up question/concern.

A Leap of Faith CDC
Permission for Television and Video Viewing

This letter should serve as notice to the parents of the A Leap of Faith CDC that the ALOF staff must have permission to allow the children in the preschool program to view instructional/entertainment programming via television or video during the program year. The television or video viewing will be limited to not more than one (1) hour per day and not more than two (2) days a week.

Please sign below indicating if you will allow/not allow your child to view programs via television or videos in their classroom.

- I give permission for my child to view videos or television in school.

- I do not give permission for my child to view video or television in school.

Child's Name

Parent's Name

Date

A Leap of Faith CDC

1715 W 4th Street

Photography Release

For valuable consideration received, I _____ grant my full and irrevocable consent to A Leap of Faith CDC to use the photograph for display or social media.

By my signature below, I understand that such grant allows the use of these photographs in display in classroom or social media.

Photo Subject:

Child's Name: _____

Signed: _____

Witness: _____

Date: _____

Consent by Parent or Guardian, In case of Minor

As a parent or legal guardian of person(s) named above, I consent to the terms of this release form.

Signed: _____

Witness: _____

Date: _____

**A Leap of Faith CDC / Redding Full Day Preschool
1715 W 4th Street
Wilmington, DE 19805**

Permission for Computer Usage

This letter should serve as notice to the parents of the A Leap of Faith CDC staff must have permission to allow the children in the preschool program to view instructional and/or supervised age-appropriate entertainment programming via computers

Please sign below indicating if you will permit/not permit your child to use programs via computers in their school.

- I give permission for my child to view and access programs on the computer in school.

- I do not give permission for my child to view and access programs on the computer in school

Child's Name

Parent's Signature

Date

**A Leap of Faith CDC/ Redding All Day Preschool
1715 W 4th Street
Wilmington, DE 19805**

Field Trip Permission Slip

I, _____ hereby give permission for _____
(parent) (child)

to attend all ECEAA sponsored field trips during the 2020– 2021 school year. I understand that public/chartered transportation will be used for trips. I agree to not hold Christina Cultural Arts Center liable for any incident that may occur.

Parent Signature: _____ Date: _____

PERMISSION FOR PROGRAM SCREENING

CHILD'S NAME _____ **CENTER NAME – A Leap of Faith CDC/Redding Full Day Preschool**

MEDICAID # _____ **DATE OF BIRTH** _____ **SEX** _____

The following program screenings are required or recommended by A Leap Of Faith CDC/Redding Full Day Preschool

DENTAL SCREENING – The parent is required to escort their child to their initial screening to obtain the results to be given to Head Start. A screening shall include one or all the following: an oral examination, cleaning, fluoride and/or x-ray. If the child qualifies, he/she will be seen at a Public Health Dental Clinic for the initial screening and follow-up treatment. All Dental Public Health forms need to be completed by the parent.

DEVELOPMENTAL SCREENING – An assessment of a child's abilities in the areas of speech, language, large and small motor development, and cognitive skills. These results will help us assess your child's future success in school. This screening is done by the local school district personnel

LEAD SCREENING – Has to be done by your physician

VISION SCREENING – Visual acuity and Strabismus screenings are done to screen the child's ability to see at a distance and to assess eye coordination.

I have been informed about the above screenings and give permission form them to be performed on my child. I also give permission for the results to be shared on a need-to-know basis between A Leap of Faith CDC/Redding Full Day Preschool Public Health, WIC, private dentist or physician, appropriate local school and/or district.

_____ Signature (Parent/Guardian) Date _____

_____ Signature (Family Service Coordinator) Date _____



A Leap Of Faith CDC/ Redding Full Day Preschool ADULT INCOME ELIGIBILITY FORM

PART 1 (Complete one application per household. Please use a pen, not a pencil.)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related." List names of Enrolled Adult Participants.	Adult's First Name	MI	Adult's Last Name	Date of Birth	Ethnicity Hispanic or Latino?		Race (check one or more)				
					Yes	No	American Indian or Alaskan Native	Asian	Black Or African American	Native Hawaiian or Other Pacific Islander	White
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 2 - ENROLLMENT

Start Date: _____ **Arrival Time:** _____ **AM/PM** _____ **Departure Time:** _____ **AM/PM** _____ **Shift Work:** _____ **Yes/No** _____

Normal days of week Participant(s) is/are in care (circle all that apply): _____ **Mon** _____ **Tues** _____ **Wed** _____ **Thurs** _____ **Fri** _____ **Sat** _____ **Sun** _____

Meals eaten at Providers/Center: (Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant):

Breakfast _____ **AM Snack** _____ **Lunch** _____ **PM Snack** _____ **Supper** _____ **Evening Snack** _____

PART 3 - HOUSEHOLD INCOME

Do any Household Members (including you) currently receive one or more of the following assistance programs: SNAP, SSI, or Medicaid?
Check one: Yes / No

If you answered NO - Complete the Income section of Part 3.
If you answered YES - Write the name and case number for the person who receives benefits below, then go to Part 4.

NAME: _____ **CASE NUMBER:** _____

All Adult Household Members (including yourself)
List all Household Members not listed in Part 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is not income to report.

Names of ALL Household Members including spouse and dependent children of participant(s) (First/Last)	Earnings from Work (Before Deductions)	How Often?				Public Assistance/ Child Support/ Alimony	How Often?				Pensions/SSI/ Retirement/ All Other Income	How Often?			
		Weekly	Bi-Weekly	2x Month	Monthly		Weekly	Bi-Weekly	2x Month	Monthly		Weekly	Bi-Weekly	2x Month	Monthly
1	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 - CONTACT INFORMATION and ADULT SIGNATURE

An adult household member must **sign and date** this form before it can be approved.
"I certify (promise) that all information on this application is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving the meals may lose the meal benefits, and I may be prosecuted under applicable State and Federal laws."

Total Household Members (Children and Adults) _____ **Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household** * * * - * * - _____ **Check if No SSN**

Street Address (if available) _____ **City** _____ **State** _____ **Zip** _____ **Daytime Phone and Email (optional)** _____

Printed Name of adult completing the form _____ **Signature of adult completing the form** _____ **Today's Date** _____

SPONSOR USE ONLY:

Categorical Eligibility (If Yes, Check One): SNAP (Food Stamp) SSI Medicaid **DATE WITHDRAWN:** _____

Total Household Income: _____ Family Size: _____ (Include all Participants)
Yearly Income Conversion: **Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12**

ELIGIBILITY - Based on the information provided, this application will be:
 Approved FREE Approved REDUCED Denied - The meals will be claimed in the PAID category.

Determining Official Signature: _____ Review/Effective Date: _____

**Instructions for Completing the
Child and Adult Care Food Program (CACFP)
Income Eligibility Form**

Please complete the Child and Adult Care Food Program Income Eligibility Form using the instructions below. Sign the form and return it to the center/sponsor. Call the center/sponsor if you need help.

PART 1: PARTICIPANT(S) INFORMATION:

- Print the name(s) of all Participant(s) enrolled.
- **RACIAL/ETHNIC IDENTITY:** We are required to ask for information about the participant's race and ethnicity. This information is important, and helps us to make sure we are fully serving the community. Responding to this section is optional, and does not affect the participant's eligibility.

PART 2: ENROLLMENT

- Start date, arrival and departure times, normal days and normal meals must be completed at the time of enrollment and/or renewal.

PART 3: HOUSEHOLD INCOME

- List current SNAP, SSI, or Medicaid Case Number for the participant. **DO NOT** complete the Income section. **Go to PART 4.**

ALL Household Members (including yourself) complete this section. List all Household Members even if they do not receive income. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is not income to report.

- Write the names of everyone in your household.
- Write the amount of income received last month for each household member (the amount before taxes or before anything else is taken out), and where it came from, such as earnings, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount *last month* was more or less than usual, write that person's usual income.

Note to Center/Reviewer: If you are uncertain of how the family receives income (monthly, weekly, bi-weekly, annually) consider the income reported as the income for the month. If this is not workable, contact the family for clarification.

INCOME TO REPORT		
Earnings From Employment: Wages/Salaries/Tips Strike Benefits Unemployment Compensation Worker's Compensation Net income from self-owned business or farm	Pensions/Retirement/Social Security: Pensions, Supplemental Security Income Cash withdrawn from savings, Retirement Income Veteran's Payments Social Security Regular contributions from persons not living in the household	Other Income: Disability Benefits Interest/Dividends Income from Estate/Trusts/Investments Net Royalties/Annuities Net Rental Income Any Other Income
Welfare/Child Support/Alimony: Public Assistance Payments Welfare Payments Alimony/Child Support	Military Household: All cash income, including military housing/uniform allowances Does not include "in-kind" benefits NOT paid in cash (base housing, medical care, clothing, food, etc.)	Foster Child's Income: ONLY funds from welfare agency identified by category for personal use of child (clothing, school fees, etc.), funds from child's family for personal use, and earnings from other sources (i.e., occasional or part-time employment) need to be included. DO NOT count funds from welfare agency for shelter, care, etc.

PART 4: CERTIFICATION - SIGNATURE AND SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART.

- All Income Eligibility Forms must have the signature of an adult household member.
- The adult household member who signs the form must include the **last four digits** of his/her Social Security Number **IF** the participant is eligible for "free or reduced" based on household income. Section 9 of the National School Lunch Act requires that unless the participant's SNAP (food stamp), TANF case number is provided or the participant is a foster child or homeless, you must include the last four digits of the Social Security Number of the household member signing the statement, or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last 4 digits of the Social Security Number is not mandatory, but if a Social Security Number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP or TANF office to determine current certification for receipt of SNAP or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal action. If he/she does not have a Social Security Number, check the "I do not have a Social Security Number" box.
- If listed a **SNAP, SSI, or Medicaid** case number, the last four digits of a Social Security Number **is not** needed.

SPONSOR USE ONLY – Eligibility Determination: To be completed by ADULT Care Representatives ONLY. (1) Complete total household income and size section. Compare total Income to *Household Income Eligibility Guidelines*. When household incomes are listed from different pay persons, you must convert all income to yearly income using the conversion table listed. Follow other instructions as indicated. (2) The review/effective date can be made retroactive back to the first day of participation in the CACFP as long as it occurs in the same month this form is received.

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, i.e., Food Stamp), Temporary Assistance for Needy Families (TANF) Program 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.*

USDA Nondiscrimination Statement (October 14, 2015)

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, audiotope, 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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.