Glassboro Child Development Centers

2022-2023 Preschool Registration Forms

Student's Name: _____
Date of Birth: _____ Current Age: _____ Sex: _____M _____F
Diaper/Pull up Size: _____
Parent's Name: _____
Email: _____
Does your child have any allergies or food restrictions or require medication? YES NO
**If yes, see below:*
If yes, GCDC *requires* documentation for review prior to enrollment. GCDC may need additional time and resources to secure the necessary accommodations for your student. This could delay enrollment and start date so please provide as soon as possible.

Child Care Resources: WFNJ NJCK DCP&P
Case Worker: _____ Phone: _____

Fees and Costs

_____ Your nonrefundable registration fee of $50 (per child) plus your first week's payment are due at the time of registration. At time of registration, you are expected to create a ProCare account and pay these fees using the app to complete registration.
_____ Your account is billed each Friday (an invoice will be sent) and your tuition payment is automatically deducted each Monday. Tuition assistance programs may help cover some of these fees -- please see the back for more information.

PROCARE Enrollment and Communication App

_____ All families are required to create a ProCare account at time of registration by downloading the ProCare Parent app to their cellphone. Please note, you are not fully registered until your ProCare account is confirmed. This app is used for all communication, including attendance, payments, weekly/monthly calendars, parent/staff communication and other news.

IEP, 504 Plans, Medication, and Special Accommodations

_____ All applicable documentation is to be attached to the application upon registration. If your child requires medication, it must be provided along with the appropriate medical forms. Medical forms are available for pick up at our main office or on our website at: www.glassborochilddevelopmentcenters.org.

_____ All medications are to be in their original packaging with the pharmacy label clearly detailing your child's information. If applicable, GCDC may need additional time and resources to secure the necessary accommodations for your student. This could delay enrollment and start date so please provide as soon as possible.

PROGRAM REQUIREMENTS

_____ Students are expected to attend at least 80% of their enrolled slot (EX: FT = at least 4 days a week)
_____ Students and parents/guardians are expected to participate in surveys and forums that help with the data collection needed for grant reporting throughout the year.
_____ Parents/guardians are expected to participate in family engagement activities at least three times per year.

Tuition Assistance

_____ Childcare subsidy programs exist to help cover weekly tuition costs if eligible. The following describes these options:

*Please keep in mind that if you are eligible and wanting to use your tuition assistance, a valid contract must be received by our agency before your child can begin. Applying for tuition assistance can take some time, so please do not delay this process.

- ***Rutgers (CCR&R)*** Tuition Assistance: income-based childcare subsidy that requires parents/ guardians to work 30+ hours per week, enrolled in 12 semester credits in college or school, or a combination of both. To apply, please contact the Rutgers CCR&R located in Woodbury at (856) 537-2322.
- ***United in Care*** Tuition Assistance: income-based tuition assistance *for families who applied to Rutgers and was denied due to over-income reasons.* Proof of Rutgers' denial is required to process a UIC application. Please contact Itzaida Romero at our main office for more information at iromero@gcdckids.net.

Please note anything that you think would be helpful to us in preparing to care for your child:

_____
_____
_____
_____
_____
_____
_____

FOR STAFF USE ONLY:			
PREK3 PREK4	*Initial*		*Initial*
Packet Complete	_____	Photo Release (1) copy file, orig. office	_____
Fee Agreement	_____	CCFP (1) copy, orig. office	_____
Registration Paid	_____	ER Form (2) copy file, copy office, orig. site	_____
1st Week Paid	_____	Medication, IEP, 504 Plan (1) copy file, orig. site	_____
Set up ProCare Acct. w/ Parent	_____	Update/Create Child's Folder	_____
Enter/Update ProCare		Tuition Assistance Contract Received *Date Received:*	

EMERGENCY AND RELEASE INFORMATION

INITIATED:_____
REVISED:_____
REVISED:_____

SITE:_____

Child's Name:_____
Date of Birth:_____
Address:_____
_____
Home Phone: _____

Parent's Name:_____
Address (if different)_____
_____
Employer:_____
Work Phone:_____
Cell Phone:_____
E-Mail: _____

Parent's Name:_____
Address (if different)_____
_____
Employer:_____
Work Phone:_____
Cell Phone:_____
E-Mail: _____

*** IS THERE A COURT ORDER (CUSTODY OR RESTRAINING ORDER) INVOLVING THIS CHILD? ____ YES ____ NO**
IF YES, WE MUST HAVE A COPY, COMPLETE WITH JUDGE/CLERK'S SIGNATURE AND DATE.

****

PARENTS WILL BE CALLED FIRST IN CASE OF EMERGENCY!

IF PARENTS ARE NOT AVAILABLE THE PEOPLE LISTED BELOW WILL BE CONTACTED. IN ADDITION ONLY THE PEOPLE LISTED ON THIS FORM ARE AUTHORIZED TO PICK UP YOUR CHILD.

1. Name:_____ Relationship:_____
   Address:_____ Home Phone:_____
   _____
   Employer:_____ Position:_____
   Address:_____
   _____ Work Phone:_____

****

2. Name:_____ Relationship:_____
   Address:_____ Home Phone:_____
   _____
   Employer:_____ Position:_____
   Address:_____
   _____ Work Phone:_____

****

3. Name:_____ Relationship:_____
   Address:_____ Home Phone:_____
   _____
   Employer:_____ Position:_____
   Address:_____
   _____ Work Phone:_____

****

4. Name:_____ Relationship:_____
   Address:_____ Home Phone:_____
   _____
   Employer:_____ Position:_____
   Address:_____
   _____ Work Phone:_____

EMERGENCY MEDICAL CARE

THIS CONFIDENTIAL HEALTH RECORD WILL ONLY BE USED TO ENSURE THE SAFETY OF THE CHILDREN IN THIS PROGRAM. THIS INFORMATION WILL NOT BE SHARED OUTSIDE OF THIS CHILD CARE PROGRAM. FEEL FREE TO CONTINUE YOUR NOTES ON AN ATTACHED SEPARATE SHEET.

1. If my child requires emergency medical care and I cannot be reached, I give my consent to Glassboro Child Development Centers to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.
2. This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.

Student's Doctor: _____ Insurance Company: _____

Phone: _____ Policy Holder's ID: _____

Allergies: _____ Child's Social Security #: _____

Last Tetanus: _____ **Religious Preference:** **(optional)** _____

Doctor's Address _____

Additional Comments: _____

Please provide your child's medical history.

CONDITION	YES (if yes, write approx. date)	NO
Asthma	☐ _____	☐
Convulsions/Seizures	☐ _____	☐
Diabetes	☐ _____	☐
Ear Infections	☐ _____	☐
Chicken Pox	☐ _____	☐
Measles	☐ _____	☐
German Measles	☐ _____	☐
Rheumatic Fever	☐ _____	☐
Mumps	☐ _____	☐
Corrective Device (glasses, hearing aid, etc.)	☐ _____	☐
Does your child use an inhaler?	☐ _____	☐

ALLERGY	YES	NO
Penicillin	☐	☐
Insect Stings	☐	☐
Foods	☐	☐
Plants	☐	☐
Hay Fever	☐	☐
Topical ointments	☐	☐
Other	☐	☐

If "yes" to any of the above, please specify allergy and describe reaction.

List significant illnesses or surgeries. Provide the date and any instructions.

Special situations or needs that staff should be aware of:
☐ Child has behavioral/emotional difficulties
☐ Child has physical disabilities
☐ Child has IFSP, IEP or 504 Accommodations Plan We must receive this prior to first day of attendance

Special Health Care Needs

Does your child have special health care needs that require treatment and/or medication? ☐ YES ☐ NO

If yes, please complete the Administration of Medication, Food Allergy Action Plan, & Care Plan for Children with Special Needs.

3. I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this GCDC Program.

_____

Parent/Guardian Signature

Date

PARENT HANDBOOK /POLICY RECEIPT ACKNOWLEDGEMENT

Dear Parent:

In keeping with New Jersey's child care center-licensing requirements we are obligated to provide you, as the parent of a child enrolled at our center, with this statement as well as other policies attached. *During COVID-19, the Office of Child Care Licensing guidelines do not permit parents to enter our childcare center buildings.

Please read the policies carefully and if you have any questions, feel free to contact me by calling 856-881-3331.

Sincerely,

Joan E. Dillon, Executive Director

Please complete and return this portion to the center. (Please print)

I, _____, have received and read the following policies for Glassboro Child Development Centers, outlined in the parent handbook for my child's program:

___ Administration of Medication
___ Breastfeeding *(Preschool Only)*
___ Communicable Diseases
___ Completion of Assessment *(Preschool Only)*
___ Diapering *(Preschool Only)*
___ Fees and Fee Schedules
___ Hand Washing Guidelines
___ Information to Parents (DYFS)
___ Nutrition and Physical Activity
___ Parent Grievance
___ Right to Refuse Services
___ Screen Time
___ Structured Assessment
___ Toilet Training *(Preschool Only)*
___ Transportation
___ Attendance *(Preschool Only)*
___ Child Behavior/Discipline/Expulsion
___ Communication/Notification
___ Dental Health *(Preschool Only)*
___ Family Engagement
___ Grievance
___ Inaccessibility to Toxic Substances
___ Late Pick Up
___ Parent/Family Code of Conduct
___ Release of Children
___ Safe Sleep *(Preschool Only)*
___ Screening/Referral *(Preschool Only)*
___ Supervision of Children
___ Transition *(Preschool Only)*
___ Use of Technology and Social Media

I agree to abide by the above policies AND other procedures contained in the parent handbook.

_____
Parent/Guardian signature

_____
Date

_____
Agency Witness

Names of child/children:
_____
_____
_____
_____

**** THIS PAGE MUST BE RETURNED BEFORE YOUR CHILD ENTERS OUR PROGRAM.**

BLANKET PERMISSION SLIP

Note: A specific Permission Form will be given to you for every trip. In the event that we have not received a completed form or your child was absent at the time the forms were distributed, this Blanket Permission Form will be used along with your verbal permission.

When signed below, this form allows your child to participate in the following activities and services, offered by the Glassboro Child Development Center:

Supervised activities at the Center;

Supervised walks away from the Center;

Emergency treatment by a physician or dentist in his office or at a hospital (as determined by qualified personnel or the EMT in Glassboro).

Permission is given for all the activities and services specified above by signing this form. My child is in good health and can participate in the normal activities of the GCDC programs. Furthermore, any conditions or special needs that may require special accommodations are described below.

_____

_____

_____

_____

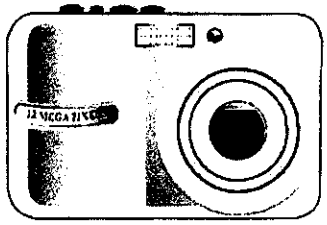
SIGNATURE:_____

RELATIONSHIP TO CHILD:_____

DATE:_____

Glassboro Child Development Centers

Photo Release Form



Please select site:

- [ ] Preschool
- [ ] RASKEL@Rodgers
- [ ] Horizon @Bullock-Grades1-2
- [ ] JURASSIC@Bullock-Grades 3-5
- [ ] JURASSIC@Bowe-Grades 6-8

I, _____, herby ____consent/____do not consent to and authorize Glassboro Child Development Centers the right to use the name of, photograph or likeness of, and statements made by _____ (child's name), a minor, in support of the commercial and noncommercial activities, including fundraising operations, videos and social media.

The undersigned acknowledge that no compensation or payment shall be made by the Glassboro Child Development Centers in return for this consent or authorization on the use publication of name, the photograph or likeness of video films or statements of this minor.

This release shall remain in continuous effect until withdrawn in writing by the undersigned.

Child's Name: _____ Date of Birth: _____

Parent/Guardian's Name (print): _____

Parent/Guardian's Signature: _____

Address: _____

Date: _____ Witness: _____

Sleeping

1. What is your child's current sleep schedule?

Morning Wake-up _____ Evening Bedtime _____ Daily Naps: _____

2. Is your child sleeping throughout the night? Yes No

3. Are there any specific bedtime routines at home? _____

4. Does your child sleep with a special blanket, toy or "lovey", or pacifier? Yes No

If yes, explain: _____

5. Does your child sleep on his or her back or stomach? _____

*If your child is younger than 4 months old, your child will always be put in crib on his or her back. If your child is between 4 and 10 months old, you must provide a doctor's note to allow our staff to place the child in a different position when placed in the crib. **PLEASE NOTE: WE PROHIBIT PILLOWS/SOFT BEDDING AND REQUIRE SNUG-FITTING SHEETS FOR INFANTS TO REDUCE THE RISKKOF SUFFOCATION.**

Social and Emotional Development

1. Has your child attended childcare before? Yes No

2. Is there anything we should know about your child's play with other children, by themselves, any concerns? _____

3.What kind of activities does your child.enjoy? Are there any activities that your child avoids?

_____

4. Does your child have any siblings? _____

5. Who lives at home? _____

6. Does your child have any favorite songs or games that comfort them? _____

_____

7. What are your expectations and hopes for your child at our center? _____

_____

8. Is there anything regarding your family, extended family or child that you would like to share with us. Any other questions or concerns that you would like to share? _____

_____

_____

_____

_____

Name of Person completing this form: _____

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

      Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

ADMINISTRATION OF MEDICATION

The following information is to be completed by the Child's health care provider:

Child's Name:_____ Birth date:_____ Wt:_____

Medication:_____ Allergies:_____

Dosage:_____ Route:_____

Time of day medication is to be given:_____

Purpose of medication:_____

Special Instructions:_____

Possible side effects:_____

Start date:_____ End Date:_____

_____ _____ _____

Signature of Health Care Provider | Phone Number | Date

The following is to be completed by the parent or guardian:

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I9 understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine. I authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director or the Director's Designee to contact the health care provider regarding my child's health, if necessary.

I usually do the following to make giving medication to my child easier:_____

_____

_____

_____

Amount of medication brought to Child Care:_____

Date:_____ _____

Signature of Parent or Guardian

Date & amount of medication returned to Parent:_____

_____ _____

Signature of Director/Director Designee | Signature of Parent/Guardian

Demographic Information Sheet

Today's date: _____

Child's name (first/middle/last): _____

Child's date of birth (MM/ DD/YYYY): _____ / _____ / _____

If child was born premature, # of weeks premature: _____

Child's gender: ○ Male ○ Female

Child's race/ethnicity: _____

Child's birth weight (pounds/ounces): _____

Parent/primary caregiver's name (first/middle/last): _____

Relationship to child: _____

Street address: _____

City: _____

State/province: _____ ZIP/postal code: _____

Home telephone: _____ Work telephone: _____

Cell/other telephone: _____

E-mail address: _____

Child's primary language: _____

Language(s) spoken in the home: _____

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ASQ-3™

Child's primary care physician: _____

Clinic/location/practice name: _____

Clinic/practice mailing address: _____

City: _____

State/province: _____ ZIP/postal code: _____

Telephone: _____ Fax: _____

E- mail address: _____

Please list any medical conditions that your child has: _____

_____

Please list any other agencies that are involved with your child/ family:

_____

_____

Program Information

Child ID #: _____

Date of admission to program: _____

Child's adjusted age in months and days (if applicable): _____

Program ID #: _____

Program Name: _____

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Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

◯ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

◯ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

_____

Parent's or guardian's signature

_____

Date

Child's name: _____

Child's date of birth: _____

If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's primary physician: _____

strengthening families

protective factors survey

Agency ID:	
Participant ID#:	

1. Date of Completion:	/ /	
2. How was the survey completed?	☐ Completed in face-to-face interview ☐ Completed by participant online at program site ☐ Completed by participant on paper at program site ☐ Completed by participant online outside of program site ☐ Completed by participant on paper outside of program site	
3. Sex:	☐ Male ☐ Female	
4. Age (in years):		
5. Race/Ethnicity (please choose the ONE that best describes what you consider yourself to be):	☐ Native American or Alaskan Native ☐ African American ☐ Hispanic or Latino ☐ Native Hawaiian/Pacific Islander ☐ Multi-Racial ☐ Other: _____	☐ Asian ☐ African National/Caribbean Islander ☐ Middle Eastern ☐ White (Non-Hispanic)
6. Marital Status:	☐ Married ☐ Single ☐ Widowed	☐ Partnered ☐ Divorced ☐ Separated
7. Family Housing	☐ Own ☐ Shared housing with friends/relatives ☐ Homeless	☐ Rent ☐ Temporary (shelter, temporary with friends/relatives)
8: Family Income:	☐ $0 - $10,000 per year ☐ $20,001 - $30,000 ☐ $40,001 - $50,000	☐ $10,001 - $20,000 ☐ $30,001 - $40,000 ☐ More than $50,001
9. Highest Level of Education:	☐ Elementary or Junior High School ☐ High School Diploma or GED ☐ Some College ☐ 4-Year College (Bachelor's Degree) ☐ Ph.D. or Other Advanced Degree	☐ Some High School ☐ Trade/Vocational Training ☐ 2-Year College (Associate's Degree) ☐ Master's Degree
10. Which, if any, do you currently receive? Check all that apply.	☐ Food Stamps ☐ Earned Income Tax Credit ☐ Head Start/Early Head Start Services	☐ Medicaid (State Health Insurance) ☐ TANF ☐ None of the Above

11. Please tell us about the children living in your household:			
Child 1:	Sex:	☐ Male ☐ Female	
	Birthdate:	/ /	
	Your Relationship to Child:	☐ Birth Parent ☐ Grandparent ☐ Other Relative ☐ Other	☐ Adoptive Parent ☐ Sibling ☐ Foster Parent
Child 2:	Sex:	☐ Male ☐ Female	
	Birthdate:	/ /	
	Your Relationship to Child:	☐ Birth Parent ☐ Grandparent ☐ Other Relative ☐ Other	☐ Adoptive Parent ☐ Sibling ☐ Foster Parent
Child 3:	Sex:	☐ Male ☐ Female	
	Birthdate:	/ /	
	Your Relationship to Child:	☐ Birth Parent ☐ Grandparent ☐ Other Relative ☐ Other	☐ Adoptive Parent ☐ Sibling ☐ Foster Parent
Child 4:	Sex:	☐ Male ☐ Female	
	Birthdate:	/ /	
	Your Relationship to Child:	☐ Birth Parent ☐ Grandparent ☐ Other Relative ☐ Other	☐ Adoptive Parent ☐ Sibling ☐ Foster Parent
If there are more than four children living in the household, please use the blank space on the back of this page.			

strengthening families

Part One: Please CIRCLE the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems.	1	2	3	4	5	6	7

Part Two: Please CIRCLE the number that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Agree
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

strengthening families

Part Three: This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child's age or date of birth and then answer the questions with this child in mind.

Child's Age in Years:		OR Date of Birth:	/ /

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
12. There are many times when I don't know what to do as a parent.	1	2	3	4	5	6	7
13. I know how to help my child learn.	1	2	3	4	5	6	7
14. My child misbehaves just to upset me.	1	2	3	4	5	6	7

Part Four: Please tell us how often each of the following happens in your family.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
15. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
16. When I discipline my child, I lose control.	1	2	3	4	5	6	7
17. I am happy being with my child.	1	2	3	4	5	6	7
18. My child and I are very close to each other.	1	2	3	4	5	6	7
19. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
20. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7

The Protective Factors Survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention (www.friendsnrc.org) in partnership with the University of Kansas Institute for Educational Research & Public Service Center through funding provided by the US Department of Health and Human Services.

Strengthening Families is a project of the Center for the Study of Social Policy (www.cssp.org).

2022 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM
ELIGIBILITY APPLICATION

NAME(S) & AGE(S) OF ENROLLED PARTICIPANT ________________ (Name) ____ (Age) ; ________________ (Name) ____ (Age)

OPTIONAL: RACIAL/ETHNIC IDENTITY OF PARTICIPANT

Check one ETHNIC identity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Mark one or more RACIAL identity (ies):
○ American Indian or Alaska Native ○ Asian ○ Black or African American
○ Native Hawaiian or Other Pacific Islander ○ White

Enrollment Information

Check (√) each day the above participant is enrolled for care, the hours of care each day, and the meal type(s) served:

DAYS OF CARE: ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN

HOURS OF CARE:
Swing / Rotating Shifts: (If Applicable) __:__ __:__ __:__ __:__ __:__ __:__ __:__

MEAL TYPES SERVED: ☐ *BREAKFAST* ☐ *A.M. SUPPLEMENT* ☐ *LUNCH* ☐ *P.M. SUPPLEMENT* ☐ *DINNER*

CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP) *(formerly Food Stamps)*, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)

If you are now receiving SNAP,TANF or FDPIR for this child, complete one of the following numbers:

SNAP CASE #________________ *OR* TANF CASE #________________ *OR* FDPIR CASE #____________

OPTION 1B: FOSTER CHILD

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

FOSTER CHILD ☐ INCOME $__________

ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete one of the following numbers:

SNAP #____________ *OR* FDPIR CASE #____________ *OR* SSI CASE # ____________ *OR* MEDICAID CASE #____________

OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2

Complete the following information: Household Members, Social Security Numbers and Income.

NAMES OF ALL OTHER HOUSEHOLD MEMBERS: *(Related and Unrelated)*	MONTHLY INCOME *(Complete One Or More - Before Deductions)* MONTHLY (Gross Earnings) WAGES / SALARY	MONTHLY SOCIAL SECURITY PENSIONS RETIREMENT	MONTHLY UNEMPLOYMENT WORKMEN'S COMPENSATION	MONTHLY WELFARE CHILD SUPPORT ALIMONY	MONTHLY ANY OTHER INCOME
1.	$	$	$	$	$
2.	$	$	$	$	$
3.	$	$	$	$	$
4.	$	$	$	$	$
5.	$	$	$	$	$
6.	$	$	$	$	$
7.	$	$	$	$	$
8.	$	$	$	$	$
9.	$	$	$	$	$
10.	$	$	$	$	$

TOTAL NUMBER IN HOUSEHOLD *(INCLUDE ENROLLED PARTICIPANT):* ______

TOTAL GROSS HOUSEHOLD INCOME: $ ____________

ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER: *(See Privacy Act Statement below)*
An Adult Household Member must sign and date this form, and list the last four (4) digits of his or her Social Security Number.
If you do not have a social security number, mark the box (☒) - "I do not have a Social Security Number".

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that all income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify this information; and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. ***An Adult Household Member must complete the following:***

Signature: ____________________ Address:____________________

Print name: ____________________ City: ____________ State: ________ Zip Code: ________

Date: ____________ Phone Number:____________________

Last four (4) digits of Social Security Number: * * * - * * - ___ ___ ___ ___ ☐ I do not have a Social Security Number

PRIVACY ACT STATEMENT: The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household member does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free or reduced priced meals. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, investigations and may include contacting employers to determine income, contacting a Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on this form.

TO BE COMPLETED BY DAY CARE AGENCY ONLY - DO NOT WRITE BELOW THIS LINE

Determination: Free ________ Reduced ________ Paid ________
Signature of Determining Official:
____________________ Date________

TOTAL MONTHLY INCOME $____________
Conversion factors to figure monthly income: Weekly x 4.33
Twice a month x 2
Every 2 weeks x 2.15

2021-2022 CHILD AND ADULT CARE FOOD PROGRAM
LETTER TO PARENT/PARTICIPANT

Dear Parent/Participant:

Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.

Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.

The income that you report must be the total gross income received by all members of your household.

The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced-priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.

Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.

The Child and Adult Care Food Program is available to all eligible participants regardless of 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. 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. To request a copy of the complaint form, call (866) 632-9992. If you have questions about any of USDA's nutrition assistance programs, check the information on the FNS web site, http://www.fns.usda.gov/cnd/. USDA is an equal opportunity provider and employer.

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.

Glassboro Child Development Centers x Yolanda Romero
(Name of Day Care Center) *(Signature of Day Care Center Representative)*

TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS.

1. List the Name of the participant *(First and Last Names)*.
2. Complete the Days, Hours of Care, and the meal types served to the enrolled participant. *(One time requirement for Adult Day Care participants.)*

Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:

If you receive SNAP, TANF, or FDPIR benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:

a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.

b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).

Option 2 – ADULT CARE PARTICIPANTS ONLY:

If you receive SNAP, FDPIR, SSI or Medicaid benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

Option 3 – CHILD CARE AND ADULT PARTICIPANTS:

If you do not receive SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

3. Names of all *(Related or Unrelated)* household members
4. List the household income *(Monthly Gross Earnings)* for each household member.
5. Total number in household *(#1 + #3 above)*.
6. Total the gross income of all household members.
7. Sign, Print and complete the full address of the Adult Household Member signing the application.
8. Date the form and complete the telephone number of Adult Household Member signing the application.
9. List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

ELIGIBILITY INCOME SCALE
Effective from July 1, 2021 to June 30, 2022

HOUSEHOLD SIZE	REDUCED		
	ANNUAL	MONTHLY	WEEKLY
1	$16,745 - $23,828	$1,397 - $1,986	$ 323 - $ 459
2	$22,647 - $32,227	$1,889 - $2,686	$ 437 - $ 620
3	$28,549 - $40,626	$2,380 - $3,386	$ 550 - $ 782
4	$34,451 - $49,025	$2,872 - $4,086	$ 664 - $ 943
5	$40,353 - $57,424	$3,364 - $4,786	$ 777 - $1,105
6	$46,255 - $65,823	$3,856 - $5,486	$ 891 - $1,266
7	$52,157 - $74,222	$4,348 - $6,186	$1,004 - $1,428
8	$58,059 - $82,621	$4,840 - $6,886	$1,118 - $1,589
Each Additional Family Member	+8,399	+700	+162