# IDENTIFICATION AND EMERGENCY INFORMATION
# CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

**To Be Completed by Parent or Authorized Representative**

| CHILD'S NAME LAST | MIDDLE | FIRST | SEX | TELEPHONE ( ) |
|---|---|---|---|---|
| ADDRESS NUMBER | STREET | CITY | STATE ZIP | BIRTHDATE |
| FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST | MIDDLE | FIRST | | BUSINESS TELEPHONE ( ) |
| HOME ADDRESS NUMBER | STREET | CITY | STATE ZIP | HOME TELEPHONE ( ) |
| MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST | MIDDLE | FIRST | | BUSINESS TELEPHONE ( ) |
| HOME ADDRESS NUMBER | STREET | CITY | STATE ZIP | HOME TELEPHONE ( ) |
| PERSON RESPONSIBLE FOR CHILD LAST NAME | MIDDLE | FIRST | HOME TELEPHONE ( ) | BUSINESS TELEPHONE ( ) |

## ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

| NAME | ADDRESS | TELEPHONE | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

| PHYSICIAN | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( ) |
|---|---|---|---|
| DENTIST | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( ) |

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

## NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

| NAME | RELATIONSHIP |
|---|---|
| | |
| | |
| | |
| | |
| | |

TIME CHILD WILL BE CALLED FOR

| SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE |
|---|---|

## TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

| DATE OF ADMISSION | DATE LEFT |
|---|---|

# CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

| CHILD'S NAME | SEX | BIRTH DATE |
|---|---|---|
| FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME | | DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? |
| MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME | | DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD? |
| IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? | | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION |

## DEVELOPMENTAL HISTORY (*For infants and preschool-age children only*)

| WALKED AT* | BEGAN TALKING AT* | TOILET TRAINING STARTED AT* |
|---|---|---|
| MONTHS | MONTHS | MONTHS |

## PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

| | DATES | | DATES | | DATES |
|---|---|---|---|---|---|
| ☐ Chicken Pox | | ☐ Diabetes | | ☐ Poliomyelitis | |
| ☐ Asthma | | ☐ Epilepsy | | ☐ Ten-Day Measles (Rubeola) | |
| ☐ Rheumatic Fever | | ☐ Whooping cough | | ☐ Three-Day Measles (Rubella) | |
| ☐ Hay Fever | | ☐ Mumps | | | |

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

| DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO | HOW MANY IN LAST YEAR? | LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF |
|---|---|---|

## DAILY ROUTINES (**For infants and preschool-age children only*)

| WHAT TIME DOES CHILD GET UP?* | WHAT TIME DOES CHILD GO TO BED?* | DOES CHILD SLEEP WELL?* |
|---|---|---|
| DOES CHILD SLEEP DURING THE DAY?* | WHEN?* | HOW LONG?* |

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH_____
DINNER

| ANY FOOD DISLIKES? | ANY EATING PROBLEMS? |
|---|---|

| IS CHILD TOILET TRAINED?* ☐ YES ☐ NO | IF YES, AT WHAT STAGE:* | ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO | WHAT IS USUAL TIME?* |
|---|---|---|---|
| WORD USED FOR "BOWEL MOVEMENT"* | | WORD USED FOR URINATION* | |

PARENT'S EVALUATION OF CHILD'S HEALTH

| IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO | IF YES, NAME OF DOCTOR: | DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO | IF YES, WHAT KIND AND ANY SIDE EFFECTS: |
|---|---|---|---|
| DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO | IF YES, WHAT KIND: | DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO | IF YES, WHAT KIND: |

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

| PARENT'S SIGNATURE | DATE |
|---|---|

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

RAINBOW-IN-A-CLOUD CDC
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

| HOME PHONE | WORK PHONE |
|---|---|
| (  ) | (  ) |

# CHILD CARE CENTER
# NOTIFICATION OF PARENTS' RIGHTS

## PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: COMMUNITY CARE LICENSING

   Licensing Office Address: 1000 CORPORATE CENTER DR. MONTEREY PARK , CA 91754

   Licensing Office Telephone #: 323-981-3350

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

***NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

***For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov***

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

## ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

***(Parent/Authorized Representative Signature Required)***

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

RAINBOW IN A CLOUD CHILD DEV. CENTER
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

***NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

***For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov***

# PERSONAL RIGHTS

**Child Care Centers**

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Los Angeles East Regional Office- Community Care Licensing

ADDRESS

1000 Corporate Center Drive Suite 200B

| CITY | ZIP CODE | AREA CODE/TELEPHONE NUMBER |
|---|---|---|
| Monterey Park, CA | 91754 | 323-951-3350 |

DETACH HERE

**TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:** **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

**ACKNOWLEDGMENT:** I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

| (PRINT THE NAME OF THE FACILITY) | (PRINT THE ADDRESS OF THE FACILITY) |
|---|---|
| Rainbow-In-A-Cloud CDC | 1800 E. Anaheim St. Long Beach CA 90813 |

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

| (TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN) | (DATE) |
|---|---|
| | |

# PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

## PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

RAINBOW-IN-A-CLOUD CDC . This Child Care Center/School provides a program which extends from 6 : 00
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to 11:30 a.m./p.m. , 5 days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

## PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

**IMMUNIZATION HISTORY:** (Fill out or enclose California Immunization Record, PM-298.)

| VACCINE | DATE EACH DOSE WAS GIVEN | | | | |
|---|---|---|---|---|---|
| | 1st | 2nd | 3rd | 4th | 5th |
| POLIO (OPV OR IPV) | / / | / / | / / | / / | / / |
| DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY) | / / | / / | / / | / / | / / |
| MMR (MEASLES, MUMPS, AND RUBELLA) | / / | / / | | | |
| HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B) | / / | / / | / / | / / | |
| HEPATITIS B | / / | / / | / / | | |
| VARICELLA (CHICKENPOX) | / / | / / | | | |

**SCREENING OF TB RISK FACTORS** (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician:_____ Date of Physical Exam: _____
Address:_____ Date This Form Completed: _____
Telephone: _____ Signature _____

☑ Physician ☑ Physician's Assistant ☑ Nurse Practitioner

**RISK FACTORS FOR TB IN CHILDREN:**

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

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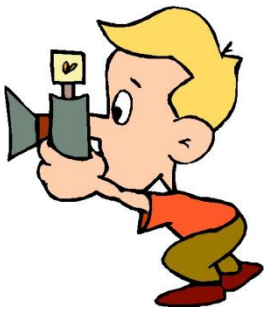
Consult with your local health department's TB control program on any aspects of TB prevention and treatment.



**RAINBOW IN A CLOUD CHILD DEVELOPMENT CENTER**

**My child _____**

**Has my permission to be taken photographs at school for marketing, field trips, photos to hang up in the classroom and advertisement.**

**Parent Signature: _____**

**Print parent name: _____**

**Date: _____**

Rainbow-In-A-Cloud Child Development Center
1800 E. Anaheim St. ▪ Long Beach ▪ CA ▪ 90813
562.256.1350 ▪ Fax 562.256.1349

# ACKNOWLEDGMENT OF REVISED PARENT HANDBOOK AND REGULATIONS

I understand that based on the rules and regulations of RIAC CDC, the following provisions apply in regards to termination of services:

- _ Parents/Guardian must comply with State Regulations and program policies and procedures, which govern the operation of the school. Failure to do so may result in termination of services.
- _ The parents/guardian must maintain a current, accurate, and updated contact list of people to call in the event of an emergency.
- _ The parent/guardian must pick up their child on time and comply with their contract time at all times. If a child is continuously picked up late this may result in termination of services.
- _ Parents/Guardian must participate in a way that maintains the smooth and efficient operation of the program and/or does not compromise the health and safety of children and/or staff.
- _ The parent/guardian must meet the contractual agreement (i.e., payment of fees), failure to follow the agreed upon child care schedule or any other program requirements as outlined in the parent handbook may result in termination of services.
- _ Termination of services may occur if a child has more than 5 unexcused or uncommunicated absences.
- _ A child may be terminated if his/her behavior presents a behavior that is a risk to children and/or staff including but not limited to: the use of profanity, threats, destroying property, or a violation of the personal rights of children and/or staff.
- _ A child will be terminated if it is determined that the preschool is unable to meet the physical, social, cognitive or emotional needs of the child.
- _ A child will be terminated if he constantly becomes a danger (i.e. kicking, hitting, biting, scratching, spitting, throwing objects, repeating profanity, etc.) to himself/herself and/or others.
- _ Fees are based on enrollment not attendance, and are non-refundable. No deduction will be made to tuition for absences, vacation, illnesses, winter or spring break, or termination of care.

**I have read and received my parent handbook and I agree to follow all rules and regulations of the child care center.**

Child's Name: _____

Parent/Guardian Signature: _____

Date : _____

# MEAL BENEFIT FORM FOR CHILDREN
# PROGRAM YEAR _____

Name of Child Care Center: RAINBOW-IN-A-CLOUD CHILD DEVELOPMENT CENTER

Please read the instructions. If you need help completing this form call: 562-256-1350

Complete, sign, and return form to: _____

**1. CHILD INFORMATION**
List names of all children enrolled for care

Check the box if the child is a foster child (the legal responsibility of a welfare agency or court).

| **Last** | **First** | **M.I.** | If all children are foster children, go to number (#) 4 and sign this form**.** |
|---|---|---|---|
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

**2. BENEFITS**
If you are receiving CalFresh, CalWORKs, or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not** complete #3. Go to #4.

| |
|---|
| CalFresh Case #: |
| CalWorks Case #: |
| FDPIR Case #: |

**3. ALL HOUSEHOLD MEMBERS**
Complete this section if you **did not** complete #2. List all household members including children enrolled for care. List all income. Go to #4.

☐ **Check here if this household receives no income.** Go to #4.

| **NAMES** | **GROSS INCOME** and how often it was received (e.g. weekly, every two weeks, twice a month, monthly, or annually)* | | | |
|---|---|---|---|---|
| **NAMES OF ALL HOUSEHOLD MEMBERS (INCLUDE THE CHILDREN LISTED ABOVE)** | **EARNINGS FROM WORK BEFORE DEDUCTIONS** | **CHILD SUPPORT, ALIMONY** | **PAYMENTS FROM PENSIONS, RETIREMENT, SOCIAL SECURITY** | **EARNINGS FROM ANY OTHER INCOME** |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |

*Applicants without income are requested to write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

## 4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

**PENALTIES FOR MISREPRESENTATION**: I certify that all of the above information is true and correct and that the CalFresh, CalWORKS, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.)

| | |
|---|---|
| Printed Name: | |
| Last Four Digits of SSN: | ☐ Check here if no SSN |
| Signature of Adult: | Date: |

## PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) 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 SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or FDPIR case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR 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 actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

## 5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions.

| If you choose to do so, please mark one or more of the following **racial** identities: | | |
|---|---|---|
| ☐ American Indian or Alaskan Native | ☐ Asian | ☐ Black or African American |
| ☐ Native Hawaiian or Other Pacific Islander | | ☐ White |
| Please mark one of the following **ethnic** identities: | | |
| ☐ Hispanic or Latino | ☐ Not Hispanic or Latino | |

## U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027), found online at 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

(3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

| **FOR AGENCY USE ONLY** | |
|---|---|
| **CATEGORICAL ELIGIBILITY**<br>CalFresh/CalWORKS/FDPIR household categorically eligible free? ☐ Yes ☐ No<br>Foster child automatically eligible free? ☐ Yes ☐ No | |
| **INCOME ELIGIBILITY** Annual Conversion: Weekly times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthl 12 | |
| Total Income: | Household Size: |
| Eligibility Classification ☐ Free ☐ Reduced-price ☐ Base | |
| Determining Official (Print Name): | |
| Determining Official Signature : | Certification Date: |

## HOW TO COMPLETE THE MEAL BENEFIT FORM

Using the instructions below, please complete, sign, and return the MBF to:

If you need help, call:

1. **CHILD INFORMATION:**
   a) Print your child's name. Print your child's name.
   b) Check box to right of name if a foster child.
   c) Include the name of the child care center.

2. **BENEFITS:** Complete this section and sign the form in #4.
   a) List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).
   b) Sign the form in #4. An adult household member must sign. You do not have to list a SSN.

3. **ALL OTHER HOUSEHOLDS:** Complete this section and sign the form in #4.
   Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. **If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.**
   a) Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
   b) If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
   c) Sign the form and include the last four digits of your SSN in #4. If you do not have a SSN, check the box "Check here if no SSN."

4. **LAST FOUR DIGITS OF SSN AND SIGNATURE:**
   a) The form must have a **signature** of an adult household member.
   b) The adult household member who signs the statement must include the last four digits of their **SSN**. If they do not have a SSN, check the box "Check here if no SSN". The last four digits of your SSN is not needed if you listed a CalFresh, CalWORKs, or FDPIR case number.

5. **RACIAL/ETHNIC IDENTITY:** You **are not required** to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

**INCOME TO REPORT**

**Earnings from Work:**
- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self- employment

**Child Support/Alimony**
- Public assistance payments
- Alimony/child support payments

**Pensions/Retirement/Social Security**
- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

**Other Monthly Income**
- Disability benefits
- Cash withdrawn from savings
- Interest dividends
- Income from estates/trusts/investments
- Regular contributions from persons not living in the household
- Net royalties/annuities/net rental income
- Military allowance for off-base housing
- Any other income

## DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

**RACE:**

**American Indian or Alaska Native**–A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

**Asian**–A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

**Black or African American**–A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

**Native Hawaiian or Other Pacific Islander**–A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**White**–A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

**ETHNICITY:**

**Hispanic or Latino**–A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term **Spanish origin** can be used in addition to "Hispanic or Latino."

**Not Hispanic or Latino**