SMALL WORLD CHILD CARE APPLICATION

Staci White, Early Childhood Director
swhite@stnicksalliance.org
211 Ainslie Street
Brooklyn, New York 11211
(718) 963-0330

Small World Child Care Center

211 Ainslie Street, Brooklyn, NY 11211
Email us: swhite@stnicksalliance.org
718-963-0330

Dear Parent or Guardian:

Our Child Care Program is for children between 2 and 4 years of age.

Please print, complete, and sign the forms included, then submit a FULL package to our office.

An initial payment should be made on the first day of school, please make checks or money orders

payable to: **Conselyea Street Block Association (CSBA)**

If you have any questions or concerns, please feel free to email or call us a call at 718.963.0330.

Sincerely,
Small World Child Care Administration

Child Care Program Application Requirements:

- ☐ Copy of Child's Birth Certificate
- ☐ Please provide tax returns and current paystub for all household members
- ☐ Child Information Forms (included in this package)
- ☐ Authorized Escort List Forms (included in this package)
- ☐ Child and Adolescent Health Examination Form – **MUST** be completed annually (included in package)
- ☐ Consent for Emergency Medical Treatment Form (included in this package)
- ☐ Child & Adult Care Food Program Form (IMPORTANT)

*****For your child's protection, we will not allow your child to leave with a person who is not on file in the main office or if we have not received a phone call or written consent from a parent or guardian identifying the new person.***

****CACFP form is very important source of funding for our school.***

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Small World Introduction:

Welcome to Small World Child Care Center! Thank you for choosing us to provide exceptional childcare to your child ~ We Are Honored!

Small World Child Care Center program is a developmental learning program designed to create a fun learning environment for your child while attending to his/her special needs. Our program provides the basic growth needs of every young child to help them develop socially, emotionally, physically, and intellectually. These areas are developed through our **Creative Curriculum**, using a variety of materials and methods designed to foster maximum development.

Their day is divided between indoor and outdoor learning activities, recreation, and rest periods. The activities are designed to contribute to the educational and social development of the children. The program also provides occasional trips within the community and special events.

Each classroom has specific programming for its age level. Large and small group activities in reading music, art, physical education, free play activities, concept development, and self-help skills are all part of the overall programming and objectives of the child's day.

Our program is comparable to both public and parochial schools in the neighborhood. The children become involved in an exciting and creative program, which helps them build skills in reading, basic math concepts, science, language development, art, music and physical awareness.

Children will receive breakfast, lunch, and snack during the day at no extra cost.

Parents will be involved in the process through take home activities, conferences and daily communication with teachers and staff.

We welcome you to the Small World Community & we are excited to become an important part of your child's life!

Child Information Form

Child's Start Date (for office use only): ____________

Child Name: ______________________________________ **DOB:**___/___/___

Last Name First Name "nickname"

Child Home Address: ____

Parent Name: ____

First Name Last Name

Parent Home Address (if different): ____________________________________

Parent Business Address: ____

Parent Business Phone: ____________________ Cell Phone: __________________

Second Parent Name: ____

First Name Last Name

Parent Home Address (if different): ____________________________________

Parent Business Address: ____

Parent Business Phone: ____________________ Cell Phone: __________________

Primary Parent Email Address: ____

Secondary Parent Email Address: ____

____

Daily Schedule		
Please select any meals your child will receive during school: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack		
Days of Child Care	Drop –Off Time	Pick-Up Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

***IN ADDITION TO THE AUTHORIZED PICK UP LIST, IN THE EVENT SMALL WORLD IS UNABLE TO CONTACT EITHER PARENT, PLEASE LIST TWO RELATIVES OR FRIENDS WHO WILL ASSUME RESPONSIBILITY FOR YOUR CHILD.**

Name: ______________________________ Relation to Child: ________________

Address: ____________________________ Phone: ______________________

____

Name: ______________________________ Relation to Child: ________________

Address: ____________________________ Phone: ______________________

Confidential Child Information Form

Child's Name (First, Last): ____

Name Child likes to be Called ____________________ Date of Birth _______________

HEALTH

Does your child have any food or medical allergies? (Peanuts, milk, chocolate, etc.)

____

Does your child require medication to be given during the time they are in school?

____

Has your child had any serious injuries, illness or corrective procedures? Describe (please provide dates and specifics): ____

____

Has your child been hospitalized? _______ Describe (please provide dates and specifics of hospitalization): ____

____

Is your child currently receiving medical treatment? _________ Describe (be specific):

____

____

Is your child able to fully participate in all aspects programs? (outdoor play etc.):

Yes___ No____ If not, please specify restriction: ______________________________

____

Check the following boxes to indicate if your child has any special needs/service:

☐ None ☐ Early Intervention ☐ Occupational Therapy ☐ Speech/ Language Therapy

☐ Physical Therapy ☐ Other: ______________________________

HOME INFORMATION

Siblings Name: ______________________ **Age:** __________

______________________ **Age:** __________

______________________ **Age:** __________

Describe your child's attitude toward sibling (s): ______________________

____

Please describe the child's relationship with each parent: ______________________

____

____

Is the child under the care of a caregiver or babysitter? ________

How many hours per week? ________

Please share any events that have occurred that may have impacted your child's life:

____

____

____

____

____

Personal Insurance Information:

Name of Policy Holder: ______________________________

Insurance Carrier: ______________________________

Policy #: ______________Group #: ______________

Primary Physician

Name: ______________________ Phone:______________

Address: ______________________________________

IN THE EVENT THAT MY CHILD NEEDS IMMEDIATE MEDICAL CARE AND NEITHER PARENT NOR EMERGENCY CONTACTS ARE AVAILABLE, I AUTHORIZE SMALL WORLD TO SEEK EMERGENCY MEDICAL TREATMENT AT THE NEAREST HOSPITAL OR TO SEEK ANY NECESSARY MEDICAL TREATMENT.

Signature: ______________________ ____Date: ______/________/______

Relationship to Child: ______________________________

SOCIAL AND EMOTIONAL DEVELOPMENT

Will your child play contentedly alone? ____________________

Approximately how long can the child play alone? ____________________

Does your child have regular playmates? __________ Ages: __________

Where do they usually play? ____________________

____

____

Were you pleased with the previous child care experience (s)? ______ If not, what would you preferred? ____________________

____

How many hours of screen time is your child allowed daily? ____________________

Do they have any favorite electronic games or TV programs? ____________________

____

What are your child's favorite activities or toys? ____________________

____

____

Is your child toilet trained? __________ Are they having accidents? __________

How often? ____________________ At night? ________ At nap? ________

How does your child tell you they need to use the bathroom: ____________________

____

Are there issues/ concerns with your child going to the bathroom? ____________________

____

Describe your child's eating habits: ____________________

What do you do if your child refuses a particular food? ____________________

____

Does your child eat with the family? Yes __________ No __________

Does your child sleep through the night? Yes________ No __________

If no, why does the child usually wake up? ____________________

How long would they stay awake? ____________________

____

Does your child have a naptime routine? Describe: ______________________________

____

Can your child dress themselves? ________________ **To what extent?** ______________

How has your child handled separating from you (in school, babysitting, camp, etc.) and what things do you say or do to ease the separation? ________________________

____

____

Briefly describe your child's personality and temperament: _________________________

____

Is there anything particular about their behavior that you feel is unique or important for us to know about? ____

What are you hoping your child will learn from attending this child care program?

____

____

____

____________________________________ ____________________

Parent or Guardian's Signature **Date**

PHOTO RELEASE CONSENT

Student Name: ____

I hereby consent to taking of photographs, movies or video tapes of the Student named above by Small World Childcare Center.

I also grant the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media

Signature of Parent/Guardian: ______________________ Date: __________

Address of Parent/Guardian: ____________________________________

PARENT and/or GUARDIAN CONSENT FOR TRIP FORM

I hereby give permission to my son / daughter, ________________________
(Child's name)

who was born on_____/_____/_______to go on **any school trips and/or daily park trips** with Small World Childcare Center located at 211 Ainslie Street, Brooklyn, NY 11211, by means of walking, **on any given school day for the current School Year of ______________.**

Should it be necessary, I give permission for my son/daughter to receive emergency medical treatment while in the care and custody of Small World while he/she is on this trip. I understand, I will be notified of the need for emergency medical treatment immediately.

____________________________ ____________________
Parent's Signature Date

____________________________ ____________________
Print Parent Name Daytime Phone #

Please note additional permission slips will be given for individual field trips

Authorized Escorts List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/ guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/ guardian as a person who is authorized to escort a child out of the center.

Instructions: The parent/ guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized escort information.

I,____, **authorize Small World**
(Parent/ guardian name)

Childcare Center enter to release my child, ____________________________________,
(Child's name)

to the individuals I have identified below:

Name: ____________________________________ Relationship to child: ______________

Home address: ____

Preferred contact number: ____

E-mail: ____

Name: ____________________________________ Relationship to child: ______________

Home address: ____

Preferred contact number: ____

E-mail: ____

Name: ____________________________________ Relationship to child: ______________

Home address: ____

Preferred contact number: ____

E-mail: ____

Name: ____ Relationship to child: ______________

Home address: ____

Preferred contact number: ____

E-mail: ____

Health Alert

Does child have any health condition that may affect participation in physical activities? Yes__ No__

Limitations ___________________ (e.g., stair climbing, participation in outdoor play)

Allergies ____

Is your child receiving any special services for this year? Yes ___ No____ Last year? Yes___ No___

Parent/ Guardian Signature:__________________________________ __**Date:** ______________

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth *(Month/Day/Year)* ___/___/______

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | State | Zip Code | School/Center/Camp Name | District Number ___ | Phone Numbers Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______

Explain all checked items above. ☐ ***Addendum attached.***

Medications *(attach MAF if in-school medication needed)* ☐ None ☐ Yes *(list below)*

______

PHYSICAL EXAM Date of Exam: ___/___/___

Height ______ cm (___ %ile)

Weight ______ kg (___ %ile)

BMI ______ kg/m² (___ %ile)

Head Circumference *(age ≤2 yrs)* ______ cm (___ %ile)

Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___ ___/___/___	______ µg/dL ______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	___/___/___	______ g/dL ______ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
OAE	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental		
Visible Tooth Decay	☐ Yes	☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes	☐ No
Dental Visit within the past 12 months	☐ Yes	☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ______	___/___/___	___/___/___	___/___/___

Report only positive immunity:

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* — **ICD-10 Code**

______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY — PRACTITIONER I.D. ☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ — **I.D. NUMBER** ☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐

Department of Health | Child and Adult Care Food Program

LETTER TO HOUSEHOLDS

Dear Parent, Guardian or CACFP Participant:

This center participates in the Child and Adult Care Food Program (CACFP). It serves healthy meals each day it is open. Please complete the attached form soon. This will help your center receive funding for the meals that are served.

You will need to complete a form every year. Your center and CACFP will keep all information private.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2018 until June 30, 2019)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	22,459	1,872	432
2	30,451	2,538	586
3	38,443	3,204	740
4	46,435	3,870	893
5	54,427	4,536	1,047
6	62,419	5,202	1,201
7	70,411	5,868	1,355
8	78,403	6,534	1,508
FOR EACH ADDITIONAL FAMILY MEMBER	+7,992	+666	+154

Small World Day Care Center
211 Ainslie St.
Brooklyn, NY 11211
(718) 963-0330

SPONSOR/CENTER OFFICIAL

SPONSORING ORGANIZATION

9/2018
DATE

This institution is an equal opportunity provider.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: ______________________________

Print the name of the child(ren) enrolled in this child care center:

1. ____________ 2. ____________ 3. ____________

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A

Food Stamp Case Number ____________

TANF Number ____________

FDPIR Number ____________

Names of Foster Children ____________

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: ____________

Date: ____________

FOR SPONSOR USE ONLY

Sponsor Agreement Number ____________

Total Household Members ____________
(including foster children, if applicable)

Total Income $____________

Free _______ Reduced _______ Paid _______

Date Determined _____/_____/_____

Signature of Center Staff ____________

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

Name of Household Members	Monthly Gross Income
1. ____________	$ ____________
2. ____________	$ ____________
3. ____________	$ ____________
4. ____________	$ ____________
5. ____________	$ ____________
6. ____________	$ ____________

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature: ____________

Print Name: ____________

SS# XXX-XX-__ __ __ __ Date: ____________

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. 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 form. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Stamps, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

Instructions for Parents or Guardians:

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household receives Food Stamps, Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the Food Stamp, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month,** before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

Instructions for Centers and Sponsors:

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The Sponsor Agreement Number.

Total Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid.*

Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, or Food Stamp, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2011 is valid until May 31, 2012.