RECURRING PAYMENT PLAN AUTHORIZATION FORM: ACH

Complete and return this form to:

Adventure Station
108 Beck Lane
Lafayette, IN 47909
(765) 474-5437

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

(Please Print)

I authorize Adventure Station , to initiate either an electronic debit, or create and process a demand draft against my Checking or Savings Account for the purpose of collecting childcare related payments. I authorize Adventure Station to withdraw sufficient funds to pay my regular childcare fees that are due and payable. I authorize Adventure Station to use the third party sender, RapidTuition, to process all payments. I acknowledge that the origination of ACH transactions to my account must comply with the provisioning of United States law.

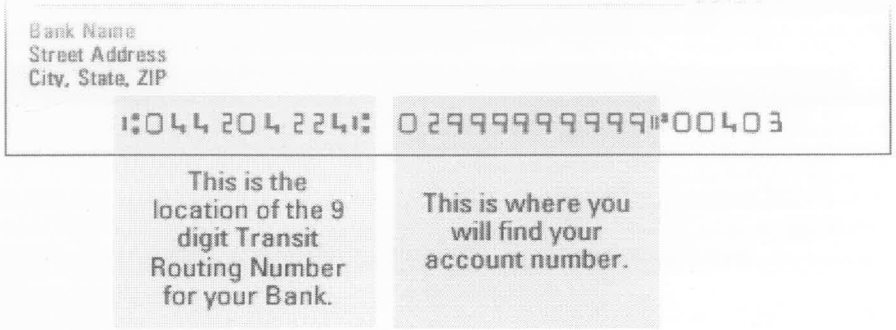
Account Holder's Name:		**Phone:**
Email:		
Children Names (if applicable):		
Please enter children names if the account holder's last name is different.		
Account Holder's Address:		
City:	**State:**	**ZIP Code:**
Bank/Credit Union Name:		
Bank/Credit Union Address:		
City:	**State:**	**ZIP Code:**
Bank Account Type: ☐ Checking ☐ Savings ☐ Business Checking		
Routing Number: *(See Sample Below)*	**Account Number:** *(See Sample Below)*	

This authorization will remain in full force and effect until I notify Adventure Station in writing of its termination. Notification must be received 5 business days in advance of termination date to permit RapidTuition and your bank reasonable time to act upon it.

Signature:	**Date:**

PLEASE KEEP A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS

(Please attach a copy of a voided check below - deposit slips not accepted)



Childcare Manager
RapidTuition
Processing Payments the Rapid Way!

(800) 553-2312
www.RapidTuition.com

INSTRUCTIONS FOR COMPLETING THE CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)

Follow these instructions, if your **household gets FOOD STAMPS OR TANF**:

Part 1: List all household members and birth dates for children.
Part 2: List the case number for any household member (including adults) receiving Food Stamps or TANF.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form and enter the contact information. The last four digits of a Social Security Number are not necessary.
Part 6: Answer this question if you choose to.
Part 7: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form and complete the contact information. A Social Security Number is not necessary.
Part 6: Answer this question if you choose to.
Part 7: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.

If some of the children in the household are foster children.

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [sponsor contact and phone number]. If not, skip this part.
Part 4: Follow these instructions to report total household income from this month or last month:

Section A – Name: List only the first and last name of **each** person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.
In Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
In Box 2 - list the amount each person got from the month from welfare, child support, alimony.
In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

INSTRUCTIONS FOR COMPLETING THE CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)

Part 5: Adult household member must sign the form, complete the information, and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.
Part 6: Answer this question if you choose.
Part 7: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:
Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box."
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Follow these instructions to report total household income from this month or last month:

Section A–Name: List only the first and last name of each person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.
In Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
In Box 2 - list the amount each person got from the month from welfare, child support, alimony.
In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: An adult household member must sign the form, complete the information, and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Sign this part it you do not want your application information shared with Medicaid or Hoosier Healthwise.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP Application for Free and Reduced Price Meals (Child Care)

Sponsor Name: First Assembly Community Ministries	Phone Number: (765) 474-5437
Center: Adventure Station	FDC Provider:

Part 1. All Household Members

Names of all household (First, Middle Initial, Last)	Birth Dates of Children	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 4 to sign this form.	Check if NO income
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Part 2. Benefits: If any member of your household received [Food Stamps] or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

Name: _____ Case number: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Insert center contact and phone number] Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: XXX - XX - _ _ _ _ ☐ I do not have a Social Security Number

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

CACFP Application for Free and Reduced Price Meals (Child Care)

A child enrolled in the day care facility may qualify for free or reduced price meals if the household income falls at or below the limits on this chart:

July 1, 2012 to June 30, 2013			
Household Size	Monthly Income	Household Size	Monthly Income
1	1,723	5	4,165
2	2,333	6	4,775
3	2,944	7	5,386
4	3,554	8	5,996
For each additional family member, add $611			

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino	☐ Asian ☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White ☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American

Part 7: OTHER BENEFITS: The law allows us to tell Medicaid and Hoosier Healthwise that your children are eligible for free or reduced-price meals. We may share your application information with Medicaid or Hoosier Healthwise unless you do not want us to. If you DO NOT want us to share this information, sign here:

_____
Signature of Parent or Legal Guardian

For information about Hoosier Healthwise health insurance
Call 1-800-889-9949

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (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 Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA and the State of Indiana are equal opportunity providers and employers."

Child Care Representative Use Only

Annual Income Conversion: Weekly X 52 – Every 2 Weeks X 26 – Twice a Month X 24 – Monthly X 12

SECTION A *Mark one of the boxes below to show how you are going to determine eligibility.*

☐ **Food stamp or TANF household**—The Food Stamp or TANF number meets the criteria for an acceptable case number. Complete Section B & C

OR

☐ **Foster child**—Compare the foster child's personal income to the guidelines. Complete Section B & C

OR

☐ **Household income**—Complete the information below and Complete Section B & C

Total Household Size: _____

Total Household Income
$_____ / _____
Example: $100/week

Compare total household income to current USDA Income Eligibility Guidelines. When the household incomes are listed for different pay periods, you must convert all income to monthly or annual income. Use the conversion listed above.

SECTION B

Based on the information provided, this application will be:

☐ Approved Free ☐ Approved Tier I
☐ Approved Reduced ☐ Approved Tier II
☐ Paid

Temporary Approval ☐ NA

This application reported zero income or a temporary reduction in household income.

☐ Approved Free ☐ Approved Reduced

Temporary approval is good for 45 days and expires on _____ (date). Re-evaluate after that date.

SECTION C

_____
Signature of Sponsor Representative

_____
Date of Approval

This form expires one year from the date it was approved

Policy Instruction 05-03

ENROLLMENT FORM

IDOE/CACFP
July 2012

Name of Institution ______________ Sponsor ID Number 35-1275741

Name of Facility Adventure Station

Child's Name: ______________ **Birthdate:** ______________

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (√) the meals your child normally receives while in care.	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__
If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc) Please check (√) here ________							

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant, and must be updated **annually**.

Printed name of parent/guardian: ______________ Phone Number: ______________

Signature of parent/guardian: ______________ Date: ______________

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care Centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed or approved private homes.
- **After School Care Programs**: Centers in low-income areas provide free snacks and suppers to School-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Adventure Station
First Assembly of God
108 Beck Lane
Lafayette, IN 47909
765-474-5437

Indiana Department of Education

CACFP Staff
School & Community Nutrition
115 West Washington Street
South Tower, Suite 600
Indianapolis IN 46204
800-537-1142 or 317-232-0850

RECORD OF MEDICATION ORDER

State Form 45877 (R3 / 10-02) / BCD 0054

CHILDCARE HEALTH SECTION
BUREAU OF CHILD DEVELOPMENT
DIVISION OF FAMILY AND CHILDREN

All medications, medicinal products, physician's sample medications, and medicinal skin care products given or used at a child care center must include the exact name of medication, dosage to be given, time to be given and reason for use. (*If used for fever, the degree of temperature must be stated.*) A physician's order is valid for one year.

1. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician	Date (*month, day, year*)
2. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician	Date (*month, day, year*)
3. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician	Date (*month, day, year*)
4. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician	Date (*month, day, year*)
5. Name of child	Exact name of medication
Dosage to be given	Time to be given (*frequency*)
Reason for use:	
Signature of physician	Date (*month, day, year*)

adventurestation
childcare, preschool, & kindergarten ministry at first assembly

All About Me

Basic Information

Name:_____

Date of Birth: _____

Mother's Name: _____

Father's Name_____

Sibling's Names and Ages: _____

_____

Pets: _____

Allergies: _____

Favorites

Favorite Foods: _____

Favorite Song: _____

Favorite Book: _____

Favorite Animal: _____

Favorite Activity: _____

Habits

How does your child eat? _____

How long does your child sleep? _____

What foods does your child dislike? _____

Does your child have any other dislikes, and if so what are they? _____

What else should I know about your child? _____

_____

_____

_____

BUREAU OF CHILD CARE
DIVISION OF FAMILY RESOURCES

SAFE TRANSPORTAION OF FOOD RESPONSIBILITY

Food must be brought to the facility in clean, insulated, sanitizable containers, which keeps cold food at 41° F or below and hot food at 135° or above. Containers must be clearly labeled with the child's name and date of preparation.

Upon receiving the food from the parent, the facility shall verify the temperature of the food. When potentially hazardous food temperature is not correct, the facility will not accept the food.

Upon accepting the food, the facility shall maintain correct food temperatures until served.

PARENT AGREEMENT

I, _____ (Parent's name) will

provide food for_____ (Child's name).

I take full responsibility for the safety of my child's food during preparation, storage, and transportation to the facility.

(Parent's Signature):_____

(Date):_____

PARENT'S NOTICE

State Form 49444 (R / 1-09) / BCC 0035

I understand that this day care ministry is not licensed under the laws of Indiana. However, I understand that this day care ministry complies with the State rules concerning sanitation and fire safety for the primary use of the structure in which it is conducted. I understand that it is my responsibility to ensure that the nutritional and health needs of my child are met while my child is at the day care ministry.

Signature of Parent or Guardian

Name(s) of children enrolled

This notice does not absolve a day care ministry from liability for injury to a child while the child is at the day care ministry if the cause of the injury is negligence or intentional wrongdoing on the part of the day care ministry or an employee of the day care ministry.

Name of facility

Address of facility (*number and street, city, state, and ZIP code*)

County