ADDRESS
7915 E 17th St
Tulsa, OK 74112

PHONE
918-660-0876

Enrollment Packet

You can fill out the forms below and bring them to the center. If you have any questions, please feel free to call us at 918-660-0876 or schedule a visit in person. Please be sure to bring the following when you visit the center:

- Shot Records
- Any Custody or Legal Docs
- Well Child Check Up (highly recommended)

Please Check One

- ☐ Private Pay (self pay)
- ☐ DHS Subsidy
- ☐ Dr. Zoellner & Associates Employee
- ☐ Z66 Auto Auction Employee

Child Schedule

Enter Time You Need Child Care Each Day (For Example- Mon 7am-5pm)

Monday	Tuesday	Wednesday	Thursday	Friday

NOTE: 3 days or more is considered full time. 2 days is considered part time, or 50% of full time rate.

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Child Information

Child's name			Sex	Date of birth
Name(s) of person(s) and the relationship with whom the child lives				
E-mail address		Area code	Home phone	
Home street address	City	State	Zip	
Mother/guardian's place of employment		Business, cellular, or page phone number		
Father/guardian's place of employment		Business, cellular, or page phone number		

Emergency contact

In case of emergency, if the parent or guardian cannot be reached, list person(s) to notify, in order of preference:

Name	Phone

Immunization record

Attach a copy of the immunization record or follow the Oklahoma State Department of Health exemption procedures. **Keep your child's immunizations current. Give updated immunization record copies to the child care facility.**

A child two months of age or older cannot be admitted to a child care facility unless the parent presents certification from a licensed physician or authorized representative of any state or local Department of Health that such child has received or will receive immunizations at the medically appropriate time.

Health record

Child's physician or clinic			Phone
Street address	City	State	Zip

Does your child have any individual special needs involving routine care, behavior and guidance, communication, or positioning? If yes, please describe:

Is your child allergic to any foods, medications, etc.? If yes, please describe:

Describe any special precautions for diet, medication, or activity, if applicable:

I give permission to the child care staff to consult with health and child development professionals regarding my child's needs. Yes ☐ No ☐

Transportation

- I do not give permission for my child to be transported. ☐
- I give permission for this child to be transported: ☐
  - to nearest medical facility, if a medical emergency occurs and I cannot be reached ☐
  - on field trips ☐
  - to and from school – Drop-off time: _____ Pickup time: _____ ☐
  - to and from home – Drop-off time: _____ Pickup time: _____ ☐
  - other, please specify: _____ ☐

Pick up permission

Persons having permission to pick up child:

Name	Phone

I understand this form is supplied by the Oklahoma Department of Human Services (OKDHS) as a service and that supplying the form in no way imposes any responsibility or obligation upon OKDHS.

The Parent's Guide to Selecting Quality Child Care, OKDHS publication number 87-91, and the *Child Care Facility Policies,* are available through your child's child care provider.

_____ _____
Signature of parent/guardian Date

Date child entered facility: _____ Date child withdrawn: _____

Instructions For Filling Out

Child And Adult Care Food Program Instructions (CACFP & FSIA) Forms Below

1. Under Part 1.A- list only the names of the children you are enrolling

2. Under Part 1.B- list all members of your house (everybody who lives in the house) Also- be sure to check the box if the household member has no income. For example, if you list your child, they will be checked no income.

3. Under Part 2- If you or a household member receives SNAP, TANF, or FDPIR benefits, write the name of the household member receiving the benefits & the case number. How to write your case number:

Write letter and first six numbers- For example: C123456

If you or a household member DO receive benefits, skip Part 3 & 4, and Fill Part 5,6 &7

If you or a household member DO NOT receive benefits, fill out all parts. Under Part 4.A, be sure to list each member of the household that has an income, and be sure to note whether it's weekly, bi-weekly or monthly.

This Page Must Be Filled Out Per Each Child

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

CHILD'S INFORMATION							
1. Child's Name:					Date of Birth:		
2. Normal Days in Attendance:	☐ Sunday	☑ Monday	☑ Tuesday	☑ Wednesday	☑ Thursday	☑ Friday	☐ Saturday
3. Head Start Facilities Only: Indicate Session.					A.M. ☐	P.M. ☐	All Day ☐
4. **Special Dietary Needs** (Attach signed medical statement):						Yes ☐	No ☐
5. Normal Hours of Attendance:	6:00 Am a.m./p.m. to				6:30 Pm a.m./p.m.		
6. Normal Meals Eaten:	Breakfast ☑	A.M. Snack ☐	Lunch ☑		P.M. Snack ☑	Supper ☐	Late P.M. Snack ☐
7. Signature of Parent/Guardian:					Date:		

PARENT'S INFORMATION		
Name of Parent/Guardian:		
Address:	City:	Zip:
Home Telephone Number:		

RENEWAL UPDATES

If there are no changes to the above information, sign and date. If there are changes, a new enrollment form must be completed, signed, and dated.

Parent/Guardian Signature	**Date**

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
FAMILY-SIZE AND INCOME APPLICATION (FSIA)

PART 1. ALL HOUSEHOLD MEMBERS

a. Name(s) of Enrolled Child(ren)

b. Names of *ALL* Household Members (First, Middle Initial, Last)	Age of Enrolled Child(ren)	Birth Date of Enrolled Child(ren)	Check If a Foster Child (The Legal Responsibility of a Welfare Agency or Court)* *If all children indicated below are foster children, skip to Part 5 to sign this form.	Check if *NO* Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

PART 2. BENEFITS

If any member of your household receives *SNAP*, *TANF*, or *FDPIR* benefits, provide the name and case number for the ***ONE*** 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 *YOUR SCHOOL, HOMELESS LIAISON,* OR *MIGRANT COORDINATOR AT 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 IS RECEIVED			
	Earnings From Work Before Deductions	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security, SSI, VA Benefits	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 also must list the last four digits of his or her social security number or mark the*** **I do not have a social security number** ***box.***

I certify that all information on this form is true and that all income is reported. I understand that the center will get federal funds based on the information that I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, this 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: **** - ** - ___ ___ ___ ___ ☐ I do not have a social security number.

PART 6: PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

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

PART 7: OTHER BENEFITS: You do not have to complete this part to participate in the CACFP.

Health Insurance

☐ Yes, I want health insurance for my children. Institution officials may give information from my FSIA to Sooner Care Health Benefit officials so that they may send me information about free or low-cost health insurance for my children.

☐ No, I ***DO NOT*** want information from my FSIA shared with Sooner Care Health Benefits officials.

I certify that I am the parent/guardian of the children for whom application is being made.

I understand that I will be releasing information that will show that I qualify for free or reduced-price meals for my children. I give up my rights to confidentialty for this purpose only.

Signature of Parent/Guardian: _____ Date: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits of this chart.

185 % of Poverty Level	
Household Size	Yearly
1	22,459
2	30,451
3	38,443
4	46,435
5	54,427
6	62,419
7	70,411
8	78,403
Each Additional Person:	7,992

In accordance with federal civil rights law and United States Department of Agriculture (USDA) civil rights regulations and policies, the United States Department of Agriculture (USDA), its agencies, office, 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 [ASL]) 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.

DO NOT FILL OUT THIS PART. THIS IS FOR OFFICIAL USE ONLY.					
Annual Income Conversion:		Weekly x 52	Every 2 Weeks x 26	Twice a Month x 24	Monthly x 12
Total Income:	Per Week:	Every 2 Weeks:	Twice a Month:	Month:	Year:
Household Size:					
Categorical Eligibility:		Date Withdrawn:	Eligibility: Free	Eligibility: Reduced	Eligibility: Denied
Reason:					
Determining Official's Signature:				Date:	