P.O Box 177
104 Main Street
Fillmore, NY 14735
Phone: (585) 567-2251
Fax: (585) 567-2541

FILLMORE CENTRAL SCHOOL

April 1, 2024

Dear Families;

Fillmore Central School will provide a Three-Year-Old Preschool Program for eligible students during the 2024-25 school year. Children born between December 2, 2020 and December 1, 2021, are eligible to participate in the 3PK program.

The Three-Year-Old Preschool Program is a **voluntary** program for parents who desire a Pre-Kindergarten experience for their children. The program

- is a half day session (8:05-11:15 or 12:15-3:13),
- follows the Fillmore Central School calendar,
- is located in the Fillmore Central School building,
- is no cost to parents,
- has a certified teacher and support staff,
- provides a developmentally appropriate curriculum focusing on cognitive, social, emotional, and physical skill development.

Unfortunately, because of additional regulations, Fillmore will not be able to provide transportation for all students in the 3-year-old preschool. The District recognizes some families are physically or legally unable to provide transportation. If your child is not attending due to an inability to provide transportation please contact Mrs. Petre.

If you are interested in your child being a member of the 2024-25 Three-Year-Old Preschool Program, please complete and return all of the enclosed Pre-Kindergarten entrance forms. In addition, please submit a copy of your child's *immunization records* and *birth certificate*. All paperwork must be submitted before your child may enter the program.

Applications must be received by July 31, 2024. The 3-Year-Old preschool program is only permitted to service eighteen students in each session. If more than thirty-six student applications are submitted, Fillmore Central will institute a lottery system to fill the preschool openings. In District students enrolled in the 3-year-old program will have first rights to the District's UPK program for 4-year-old students the following year.

If you have any questions, please contact me at 567-4432. Thank you for your interest in our 3-year-old preschool program. We look forward to receiving your child's registration information and working with you and your child.

Sincerely,
Sarah Petre
PreK-6 Assistant Principal

Fillmore Central School
3-Year Old Pre-Kindergarten
Entrance Checklist

Child's Name: _____ Date of Birth: _____

_____ Entrance Form

_____ Emergency Form

_____ Developmental and Social History Form

_____ Health Form

_____ Physical (completed by a physician)

_____ Home Language Questionnaire/ Identification of Homeless Students Form.

_____ Immunization Records

_____ Dental Health Certificate

_____ Birth Certificate

_____ Session request

Please return all forms and the checklist to:

Sarah Petre
PK-12 Assistant Principal
104 Main Street
Fillmore, NY 14735

Office use:
Date Information Received: _____

Preschool applications must be returned before July 31, 2024

Fillmore Central School Entrance Form

Student Number: _____ Grade: _____ Teacher: _____ Bus Number: _____
Date Registered: _____ First Date Attended: _____ SSN: _____

Student Information

_____ DOB: _____ Sex: M F
Last Name First Name MI __ school-age __ preschool age child

Place of Birth _____ Circle: New Student Former Student Year(s) Attended: _____

Ethnicity (Check): Is your child Hispanic/Latino or of "Spanish origin" ___ Yes ___ No
Please select one: ___ American Indian or Alaskan American ___ Asian ___ White/ Other
___ Black or African American ___ Native Hawaiian or Other Pacific Islander

□ District Resident □ Non-Resident □ Placed by DSS/ Agency Agency Name: _____

Address: _____ Telephone: _____

_____ Emergency Number: _____

How many schools has this child attended? _____ Previous School: _____
My child receives or is eligible for ___ free lunches ___ reduced price lunches. *(if known)*
My child participates in a half day vocational program. __yes (program: _____) __ no

Custodial Parent/ Guardian Information

Name: _____ Active Duty____ Relationship: _____

Name: _____ Active Duty____ Relationship: _____

Mailing Address _____

(If different from above): _____

The child's parents are: ___ Married ___ Single Parent ___ Divorced (Custody Papers: __received __ needed)
The child is in foster care: ___

Non-Custodial Parent/ Guardian Information (The following people should receive information about the child.)

Name: _____ Active Duty____ Relationship: _____

Name: _____ Active Duty____ Relationship: _____

Mailing Address: _____ Telephone: _____

_____

Census Information: Other Children in the Family

Pre-School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

In School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Special Placement Approval

I agree to the temporary continuation of the classification and programs in which my child, _____, was placed in his/her previous school prior to transferring to Fillmore Central School. My child's program included:

___ CSE (Resource Room/ Consultant Teacher/ Special Class) ___ Remedial Reading ___ Remedial Math

___ Academic Intervention Service (Area: _____) ___ Gifted and Talented Program ___ Speech

Route to: ___ CSE ___ Psychologist ___ 5-12 Office ___ District Office ___ Guidance Office
___ Mrs. Barber ___ Cafeteria ___ Attendance ___ Bus ___ Remedial ___ Speech

Identification of Homeless Students

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? *Check one box:*

Section A	Section B
☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "double-up") ☐ In a shelter ☐ In a hotel/motel, car, park, bus, train or campsite (please specify) ☐ With friends or family members (other than parent/guardian) ☐ Other temporary living situation (Please Describe) ☐ Independently ***CONTINUE:*** *If you checked a box in* ***Section A****, complete #2*	☐ Choices in Section A do not apply ☐ In permanent housing ☐ Other (Please specify) ___

2. The student lives with:

□ 1 parent
□ 2 parents
□ 1 parent & another adult
□ a relative, friend(s) or other adult(s)
□ alone with no adults
□ an adult that is not the parent or the legal guardian

Home Language Questionnaire (HLQ) CR 154 A-14

Dear Parent or Guardian:

In order to provide your child with the best possible education we need to determine how well he or she understands, speaks, reads, and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL
District/ School: Fillmore Central School
Student Name Grade
Date of Birth Student Identification Number
Country of Birth/ Ancestry
Number of Years enrolled in school outside the US
Name/ Position of school personnel completing this section
Determination: □ Possible LEP □ English Proficient

(√ boxes that apply)

1. What language(s) is spoken in the student's home or residence? □ English □ Other (specify) _____
2. What language(s) is spoken most of the time to the student, in the home or residence? □ English □ Other (specify) _____
3. What language(s) does the student understand? □ English □ Other (specify) _____
4. What language(s) does the student speak? □ English □ Other (specify) _____
5. What language(s) does the student read? □ English □ Other (specify) _____ □ Does Not Read
6. What language(s) does the student write? □ English □ Other (specify) _____ □ Does Not Write
7. In your opinion, how well does the student understand, speak, read, and write English?

	Very Well	Only a little	Not at all
Understands English	□	□	□
Speaks English	□	□	□
Reads English	□	□	□
Writes English	□	□	□

Parent/ Guardian Signature: _____ Date: _____

FILLMORE CENTRAL SCHOOL

Student Contact Information

Student Name: _____ Grade_____

Home Address: _____

Mailing Address: _____

Contact 1: *(resides with student)*

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Contact 2: *(resides with student)*

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Contact 3: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

Contact 4: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Has Custody: _____ Receives Mailings: _____

Contact 5: (DOES NOT reside with student)

Name: _____ Relationship: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address:_____

Has Custody: _____ Receives Mailings: _____

Additional/Emergency Contact Information

Contact 5:

Name: _____ Relationship_____

Phone: _____

Contact 6:

Name: _____ Relationship_____

Phone: _____

Contact 7:

Name: _____ Relationship_____

Phone: _____

After School Program or Care Provider

Name: _____

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104 Main Street
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FILLMORE CENTRAL SCHOOL

Student: _____

DOB: _____

The 3-Year-Old preschool program is only permitted to service eighteen students in each session. If more than thirty-six student applications are submitted, Fillmore Central will institute a lottery system to fill the preschool openings.

Please check/choose one session:

- o ____ the morning session (8:05-11:15)
- o ____ the afternoon session (12:15-3:13)
- o ____ either session

Please complete and return this form with your application no later than July 31, 2024.

EMERGENCY FORM
2024-2025

Student: _____
Last First Grade Teacher

***Physical Conditions Possibly Needing Special Consideration**

Allergies: _____

_____

Other Conditions: _____

In case of an accident or serious illness, I request the school contact me. If the school in unable to reach me, I hereby authorize the school to call the physician below and to follow his/ her instructions. If it is impossible to contact this physician, the school may make whatever arrangements that seem necessary.

_____ _____
Signature Parent/ Guardian Date

Physician Name: _____
Telephone Number: _____
Preferred Hospital: _____

***Early Dismissal Destination** In the event school closes early, my child will go to the indicated destination.

_____
Name Telephone Relationship

_____
Address

***Court Papers** Please indicate whether any type of court paper impacts this student (a copy of the court papers must be on file to be enforced by the school).
Are there any court papers impacting this child? ____Yes ___No
Please identify the type of court papers: _____

Standing Order for Over-The-Counter Medication Permission Form
I give permission for Fillmore Central School to administer the following OTC medication to my child to assist him/her to complete the school day. I understand this is for emergencies only and if my child needs the following medication on a regular basis I will fill out the OTC Medication Permission form and supply the OTC medication for my child.

- ☐ Tylenol/Acetaminophen
- ☐ Advil/Ibuprofen
- ☐ Hydrocortisone Cream
- ☐ Triple Antibiotic Cream
- ☐ Chloraseptic Throat Spray
- ☐ Tums
- ☐ Solarcaine
- ☐ Sun Screen

_____ _____
Parent/ Guardian Signature Date

Consent to Publish Name/ Picture

Fillmore Central School is proud of and enjoys sharing the accomplishments of students of all ages. At the same time, it is important to respect the rights of parents and guardians to not have information shared or publicized about their child. For this reason, the district is collecting parent and guardian consent to publish students' names and/ or pictures across various media.
As the parent/ guardian of _____, I am providing consent to Fillmore Central School to publish my child's picture, name, audio clips, student teaching videos, video clips and other school work in various media sources, including the school newsletter, yearbook, website, newspapers, etc.

_____ Yes **____No**

_____ _____
Parent/ Guardian Signature Date

Pre-Kindergarten ____ **Kindergarten ____**

Fillmore Central School
Pre-Kindergarten and Kindergarten
Developmental & Social History Form

CHILD NAME: _____ **DOB:** _____

Parents: The questions on this form are intended to provide school staff with information which will help us better understand your child's development, experiences and uniqueness. Please feel free to make additional comments in any area. Thank you.

Have you had concerns about any phase of your child's development?

Yes ____ No ____ Comments: _____

_____

Has your child accomplished developmental milestones at the expected ages?
(Walking, first word, speaking in sentences, toileting, etc.)
Yes ____ No ____ Comments: _____

_____

Has your child had any persistent problems with eating, temper tantrums, sleep habits, bedwetting, wetting or soiling clothes, thumb sucking, fingernail biting?

Yes ____ No ____ Please Explain: _____

_____

Has your child had any persistent fears or worries?

Yes ____ No ____ Please Explain: _____

_____

Describe how your child relates to other children: _____

_____

Which hand does your child prefer to use for eating, coloring, etc.?

Right Hand ____ Left Hand ____ Undecided ____

Has your child been referred for any professional evaluation? (Hearing, vision, psychological, or medical specialist)
Please Explain: _____

_____

At what age did your child first begin to:

Walk: _____

Speak: _____

Crawl: _____

Has your child attended any pre-kindergarten program or out-of-home day care? If so, approximant dates and age of your child. Name and program location:

	When attended/age	Name and location of program
Fillmore Pre-K		
Headstart		
Nursery School		
Day Care		
BOCES		
Other		

Please describe who is living in your home at this time:

____ Mother	____ Brother(s)	Ages: _____
____ Father	____ Sister(s)	Ages: _____
____ Step-Mother	____ Step/half brother(s)	Ages: _____
____ Step-Father	____ Step/half sister(s)	Ages: _____
____ Other Adult(s)	____ Foster Children	Ages: _____
____ Other Relative(s)	____ Other Children	Ages: _____

Non-Custodial parent name: _____

Is this person to receive school notices and communications: Yes ____ No ____

If yes, address: _____

Are there any social/family situations of which we should be aware? (Recent separation, divorce, custody issue, family illness, recent loss) _____

_____

What other things would you like us to know about your child? _____

_____

_____

Pre-Kindergarten _____ Kindergarten _____

Fillmore Central School
Pre K and Kindergarten
Health Form

Name of Child: _____ Date of Birth: _____

Place of Birth: _____

Custodial parents/guardians: _____

Address: _____ Phone: (H) _____

_____ (w-mom) _____
(w-dad) _____

Child's Physical Health History:

1. Did your child have a medically normal pre-natal delivery and newborn history?
   Yes _____ No _____ (Explain) _____
   _____

2. Has your child experienced any loss of consciousness or seizures?
   Yes _____ No _____ (Explain) _____
   _____

3. Has your child experienced chicken pox, any serious illness, accident or head injury? Yes _____ No _____ (Explain) _____
   _____

4. Has your child been diagnosed with any physical abnormality or condition?
   Yes _____ No _____ (Explain) _____
   _____

5. Has your child experienced any ear or hearing problems that you have known or suspected? (including frequent ear infections at any age).
   Yes _____ No _____ (if yes, please indicate age(s) and if treated medically)
   _____

6. Has your child experienced any eye or vision problems that you have known or suspected? Yes _____ No _____ (if yes, please indicate age(s) and if treated medically) _____

7. Does your child wear corrective lenses? Glasses _____ Contact lenses _____

8. Is there anything concerning your child which the school should know in order to provide special care in the classroom or on field trips? _____
   _____

9. Has your child had dental care? Yes _____ No _____
   Most recent date seen: _____

10. Does your child suffer from any allergies? (e.g. food, medications, insects, sun, cosmetics, etc) Please Explain: _____
    _____
    Special medication, treatments: (inhalers, bee sting kit, etc.)
    _____

11. Is your child taking any regular medications? Yes _____ No _____

    Medication: _____ Dose if known _____ for condition: _____

    Medication: _____ Dose if known _____ for condition: _____

    Will the medication need to be administered in school? Yes _____ No _____
    Other comments: _____

12. Has your child been screened for Lead levels in his/her blood?
    Yes _____ No _____ Results: _____

13. Please list your child's medical professionals and locations/phone numbers.

	Name	Address	Phone
Physician			
Eye Doctor			
Dentist			
Specialist &Specialty			
Specialist &Specialty			

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:			DOB:
SCREENINGS			
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 1st, 3rd, 5th, 7th, 9th and 11th grade. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist to fill out section 2. Return the completed form to the school nurse as soon as possible. (Fillmore Central School, Health Office, PO Box 177, Fillmore, NY 14735)

Section 1. To be completed by Parent or Guardian (please print)

Child's Name:

Birth Date: / / Month Day Year | Sex: ☐ Male ☐ Female | Will this be your child's first visit to the dentist? ☐ Yes ☐ No

School: Fillmore Central School Fax# 585-567-2541 | Grade:

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date_____

Section 2. To be completed by the Dentist

I. The Dental Health Condition of _____ **on** _____ **(date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:**

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) | Dentist's Signature

Optional Sections – If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify) _____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Community Eligibility Provision (CEP)/Provision 2 non-base year
Household Income Eligibility Form

____________________*(name/school)* is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call ____________________(school *phone number)*, if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Then skip to Part 4.

Name: ____________________ CASE #____________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: Date:

Email Address:

Home Phone

Work Phone

Home Address

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

SNAP/TANF/Foster Income   Total Household Income/How Often: Household Size:

Free Eligibility   Reduced Eligibility   Denied Eligibility

Signature of Reviewing Official

CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1 — **ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.**

(1) Print the names of the children, including foster children, for whom you are applying on one form.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2 — **HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.**

(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the form in PART 4. **SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4 — **ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.**

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.

PRIVACY ACT STATEMENT