Mount Ararat Community Activity Center

MACAC ECDC Enrollment/Intake Packet

Updated 7/31/2023

EMERGENCY CONTACT PARENTAL CONSENT FORM

Please Complete ALL BOXES or PUT N/A

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME	BIRTH DATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
EMERGENCY CONTACT PERSON(S) NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS **ADD TYPE OF INSURANCE**	POLICY NUMBER (REQUIRED) **ADD Policy #**
PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT	
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES
WALKS AND TRIPS	SWIMMING n/a
TRANSPORTATION BY THE FACILITY	WADING n/a

SIGNATURE OF PARENT OR GUARDIAN

DATE

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

PLEASE COMPLETE ALL BOXES

Childs Name:		
Fee Amount $	**Per (circle one)** Week Bi-weekly Monthly	**Day Payments are made** Friday

Services to be Provided as part of the day care fee (examples: transportation, care, meals, etc.)

10 hours of childcare services. Extended day fee of $75 a week will be incurred if a child needs to be at the center longer than 10 hours. MACAC-ECDC will provide breakfast, lunch, and afternoon snack.

Child's Arrival Time	**Child's Departure Time**	**Person(s) designated by parent to whom child may be released:**
Late Fee ***$1.00 per minute per child. After 15 minutes, $2 per minute per child***		See emergency contact form

Extra services to be provided at an additional fee if applicable.

MACAC-ECDC at times will have field trips. Advance notice will be provided for more information and possible participation.

Tuition is not adjusted for vacations. There is a $50/week fee to hold a space for medical leave up to 4 weeks with a doctor's excuse.

All payments returned from the bank NSF will be assessed with a $40 fee. Declined payments must be paid next business day.

I, the parent/ guardian: **Please ALL check boxes**

- ○ Received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)
- ○ Agree to update emergency contact/ parental consent forms information whenever changes occur or every 6 months at a minimum. (9 3270.124, 3280.124, 3290.124)

Signature- Operator	**Date**	**Signature- Parent/ Guardian**	**Date**

Date of Child's Admission	**6 Month PERIODIC REVIEW**
Date of Withdrawal	**Signature- Parent/ Guardian** **Date**

745 N. Negley Avenue • Pittsburgh, PA 15206 • P: 412-441-1868 • F: 412-441-1806

MACAC ECDC Tuition Rates

	Week	Bi-weekly	Monthly
Infants (6 weeks-12 months)	$225	$450	$900/ $1125**
Young Toddlers (13 months -23 months)	$210	$420	$840/ $1050**
Older Toddlers (24 months - 36 months)	$210	$420	$840/ $1050**
Preschool (37 months to 5 years)	$195	$390	$780/ $975**
Extended Day (over 10 hours)	$75		
Application Fee	$75 (one-time fee)		
Occasions Tardy (Drop off or pick up)	One to Five	$1 per minute per child	
	Six to nine	$3 per minute per child	
	Ten or more	$5 per minute per child	
Continued tardiness after 10 occasions may result in suspended services			

****Payments for 5th week of the month ****
Siblings receive a 15% tuition discount.

ECDC is open from 6:30 am to 6:00 pm, Monday through Friday. *Extended Day is defined as more than 10 hours of childcare services*. The fee schedule for extended day services is included in the Center's rate listing. If a child is picked up after their schedule time, parents will be charged an additional late fee based on chart above.

At the initial enrollment, a one-week payment in advance is due. Parents may make subsequent payments weekly, bi-weekly, or monthly in advance for childcare services. All payments, including private pay and ELRC co-payments, are due prior to the week of service.

If ELRC co-payments are not received, ELRC will be notified, and services will be suspended until payment is received. If payments are not received, services will be suspended until payment is received.

Childcare fees will be charged for the weeks that the child is enrolled in ECDC. Charges will not be prorated based on attendance. *All tuition fees are to be paid via auto debit deduction. NO EXCEPTIONS.*

Tuition will not be adjusted for a student who is out on vacation. There is a $50/week fee to hold a space for medical leave up to 4 weeks with a doctor's excuse. *Medical leave is defined as* facing a medical condition that reduces their physical and/or mental health to the point that they cannot be at school.

Two weeks' notice is required for withdrawals. Tuition will be charged if notice is not given.

All payments returned from the bank NSF will be assessed with a $40 fee. All declined payments will need to be paid by the next business day for services to continue. If payments are declined more than three times per year services may be terminated.

ECDC reserves the right to use a collection agency to collect fees owed and to report payment history to the credit bureaus.

Please contact the ECDC Director at 412-441-1868 with questions, concerns, or comments.

745 N. Negley Avenue • Pittsburgh, PA 15206 • P: 412-441-1868 • F: 412-441-1806

Mount Ararat Community Activity Center

EARLY CHILDHOOD DEVELOPMENT CENTER PAYMENT POLICY

The MACAC Early Childhood Development Center (ECDC) is dedicated to providing children with a safe and nurturing learning environment. For ECDC to provide quality services and maintain an environment conducive to the growth of children it serves, it is imperative that ECDC collect fees for services rendered in a timely manner.

- All tuition fees are to be paid via auto debit deduction. No exceptions.
- There will be a $75 application processing fee **
- Two weeks' notice is required for withdrawals. Tuition will be charged if notice is not given.
- Tuition will not be adjusted for if a student is out.
- There is a $50/week fee to hold a space for a medical leave up to 4 weeks with a doctor's excuse.
- Parents may make payments weekly, bi-weekly, or monthly in advance for childcare services that are received.
- All ELRC co-payments are due on Monday of each week. If payments are not received, ELRC will be notified, and services will be suspended until payment is received.
- All payments returned from the bank NSF will be assessed with a $40.00 fee. All declined payments will need to be paid by the next business day for services to continue.
- If payments are declined more than three times per year services may be terminated.

** This does not apply to ELRC, EHS, & HS Students

ECDC reserves the right to use a collection agency to collect fees owed and to report payment history to the credit bureaus.

Please contact the ECDC Director at 412-441-1868 with questions, concerns, or comments.

☐ *I have received a copy of the ECDC payment policy and agree to the terms outlined.*

Signature _____ Date _____

745 N. Negley Avenue • Pittsburgh, PA 15206 • P: 412-441-1868 • F: 412-441-1806

MACAC ACH / Debit Card Authorization Form

I, _____ hereby authorize Mount Ararat Community Activity Center (MACAC) to charge my account in the amount of $_____ beginning on date _____ for _____ (Child/Children) and ending on date _____.

Program: ECDC

My account will be billed in this amount *(check one:)* Weekly ___ Bi-Weekly ___ Monthly ___

(Note Monthly Payers: Months with 5 Mondays will be charged on the 5th Monday for the week.)

ACH Debits: PLEASE ATTACH A VOIDED CHECK FOR VERIFICATION

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Please check: Checking: _____ or Savings: _____

OR

Debit Card Authorization:

Card Number: _____ Expiration Date: _____ 3 Digit Code: _____

Name and Address as appears on the account:

Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Telephone: ( ) _____ - _____

Changes:

New Amount	Effective Date	Cardholder Initials	Director Initials

Please allow 3-5 Business days for changes to occur.

Check if canceling account/card ☐ Purpose of Cancellation: _____

Your completion of this authorization form helps us to protect you from credit card fraud. MACAC will keep all information entered on this form strictly confidential. Payment is due by Friday before services are rendered. All declined payments will be assessed a $40.00 fee.

_____ _____/_____/_____

Cardholder's Signature Date

745 N. Negley Avenue • Pittsburgh, PA 15206 • P: 412-441-1868 • F: 412-441-1806

MACAC ECDC Fieldtrip Permission Slip

Dear ECDC Families,

Our facility will be sponsoring field trips throughout the school year through Tickets for Kids, MACAC, or Head Start Supplemental. Field trips are only for children ages 3-5 years old. By signing this form, you give permission for your child to attend the field trips and to ride the MACAC vans or with contracted school buses. This permission slip will be kept in your child's file and will only need to be signed once.

Child's Name _____

Please check all that apply below:

___ My child has permission to attend all fieldtrips sponsored by ECDC.

___ My child is unable to attend fieldtrips sponsored by ECDC.

___ I would like to volunteer on fieldtrips sponsored by ECDC.

Note: Sometimes there is a cost $$ for a fieldtrip. We will let you know if there are any cost prior to the fieldtrip date.

Parent's Name: _____

Parent's Phone Number: _____

Parent's Email: _____

Emergency Contact Person: _____

Emergency Contacts Phone Number: _____

Parent's Signature: _____

Today's Date: _____

MACAC ECDC Photo Release Form

Child's Name: _____

___I give permission for my child to be photographed and for those photographs to be used by ECDC for advertising, or for our MACAC-ECDC Facebook page.

___ I do not give permission for my child to be photographed.

Parents Name: _____

Today's Date: _____

MACAC ECDC Asthma Care Plan

Child's Name:	DOB:		Date of Plan:
Allergies:			
Parent/Guardian:	Address:		Phone Number:
Child's Primary Care Physician:	Primary Care Phone #:	Child's Asthma Specialist:	Phone #:

Check all asthma triggers for your child:

- ☐ Additives/Coloring
- ☐ Emotions (Fear) (Anger) (Excitement) (Sadness)
- ☐ Seasons: Fall, Winter, Spring, Summer
- ☐ Change in weather or temperature.
- ☐ Carpets/Floor Cleaners
- ☐ Exercise/Physical Activity
- ☐ Food Odors
- ☐ Foods
- ☐ Wood Smoke
- ☐ Tobacco Smoke
- ☐ Respiratory Dust (includes chalk)
- ☐ Dogs
- ☐ Medication
- ☐ Animals (Type: _____)
- ☐ Other:

Outside Activities and Field Trips:

The following medications must be readily available when this child is participating in our activities and must be brought on all field trips and outdoor/indoor excursions:

_____

_____.

Classroom Environment:

List anything that can be done to prevent an asthma episode in this child (environmental control measures, pre-medications, dietary restrictions, etc.)

_____

_____.

Emergency Asthma Medications:

Name of Routine Medication	Method of Administration (nebulizer, inhaler, inhaler with aero chamber, and mask, oral)	Amount (tsp, tbsp., ml number)/dose (mg)	Times/Frequency

MACAC Getting to Know Your Child Form

Please fill out the form below.

Child's Name_____ Date of Birth: _____
Parent(s)'s Name(s): _____

1. What are your expectations of our program?

2. Is there any aspect of the education program especially important to your child/family?

3. Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know?

4. Are you willing to be a volunteer in our classroom? Are there any other ways you would like to be involved? Are there any other talents or interests you would like to share with us?

5. Tell me about your child's favorite toys, games, food likes and dislikes.

6. Do you typically celebrate your child's birthday? ( ) Yes ( ) No If yes, please explain:
_____.

7. Do you celebrate any other special days? ( ) Yes ( ) No If yes, please explain:
_____.

8. What are some of the annual celebrations or family gatherings that you have during the year? (Please list the dates and types of things that you do).

_____

_____.

MACAC ECDC Baby Profile Form

Name_____ Age_____ Date_____

Bottles:

Parent/guardian provides enough premade bottles for the day plus one extra	
Number of bottles provided daily:	On Demand:
Scheduled times:	

Food:

Uses fingers to feed self ? Yes No		
Meals	Time	Type of Food
Breakfast		
Lunch		
Snack		

The above feeding protocol will remain in effect until it is revised by a parent/guardian in writing.

Nap:

All babies are placed on their backs in cribs or (when old enough) on a cot.	
Personalized nap procedures/ Times;	

Physical Abilities (check all that apply)

- ☐ Rolls tummy to back
- ☐ Rolls back to tummy
- ☐ Sits propped
- ☐ Sits alone
- ☐ Scoots on tummy
- ☐ Crawls
- ☐ Pulls to stand
- ☐ Stands
- ☐ Climbs

Anything else we should know?

_____

_____.

Parent Signature:_____ Date:_____

745 N. Negley Avenue • Pittsburgh, PA 15206 • P: 412-441-1868 • F: 412-441-1806

Children Special Dietary Needs

Medical Plan of Care for Child Nutrition Programs (CACFP and SFSP)

Please read pages 1 and 2 before completing this form.

TO BE COMPLETED BY A PHYSICIAN/ MEDICAL AUTHORITY

Participant's Name	Date of Birth	Age/Classroom
Name of Center/Program/Site		
Name of Parent/Guardian or Participant's Representative	Phone Number of Parent/Guardian/Representative	
Signature of Parent/Guardian or Participant's Representative	Date	

1. Provide an explanation below of how the participant's physical or mental impairment restricts the participant's diet:

2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the participant's needs:

3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.

Foods to be omitted:

Suggested substitutions:

4. Indicate texture modifications, if applicable:

☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ Other: _____

5. List any required special adaptive equipment:

Name of Physician/Medical Authority & Title (Please Print)	Provider Phone Number
Signature of Physician/Medical Authority	Date

Signing the following section is optional, but may prevent delays by allowing the Program to speak with the physician/medical authority.

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____(medical authority) to release such protected health information of the participant as is necessary for the specific purpose of Special Diet information to _____(center/program/site) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning the participant with the childcare/adult care/ summer food program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for the participant. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____(date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is (***circle one***): **Parent Guardian Adult participant** or **Representative of participant** listed on this document and has the legal authority to sign on behalf of that person.

Signature:_____ Date:_____

745 N. Negley Avenue • Pittsburgh, PA 15206 • P: 412-441-1868 • F: 412-441-1806

Parent/Provider fill in this part.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

CHILD'S NAME: (LAST) (FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH: HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME: **Mt. Ararat Community Activity Center**	
FACILITY PHONE: **412-441-1868** COUNTY: **Allegheny**	WORK PHONE:

☐ I authorize the childcare staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)
☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT:
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Child and Adult Care Food Program
Child Enrollment Form

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child (ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	☐ MONDAY									☐ BREAKFAST
LAST NAME	☐ TUESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ A.M. SNACK
BIRTH DATE	☐ WEDNESDAY									☐ LUNCH
AGE	☐ THURSDAY	Other:								☐ P.M. SNACK
	☐ FRIDAY									☐ SUPPER
	☐ SATURDAY									☐ EVENING SNACK
	☐ SUNDAY	Enrollment Date:			Withdrawal Date:					

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	☐ MONDAY									☐ BREAKFAST
LAST NAME	☐ TUESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ A.M. SNACK
BIRTH DATE	☐ WEDNESDAY									☐ LUNCH
AGE	☐ THURSDAY	Other:								☐ P.M. SNACK
	☐ FRIDAY									☐ SUPPER
	☐ SATURDAY									☐ EVENING SNACK
	☐ SUNDAY	Enrollment Date:			Withdrawal Date:					

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (check one) ☐ **Hispanic** ☐ **Non- Hispanic**

Race (check one or more

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

CACFP INFANT FEEDING PREFERENCE / PARENT CHOICE

Please mark your preference (choose all that apply by initialing in the appropriate space)

	Today's Date _____ **Birth - 5 months**	Today's Date _____ **6 - 11 months**
I will bring expressed breast milk for my infant.		
I will come to the center to breastfeed my infant.		
I want the center to provide formula for my infant (we provide Member Mark Advantage w/ Iron		
I will bring formula for my infant. The formula is _____		

Please mark your preference	Today's Date _____ **6 - 11 months**
I want the center to provide infant cereal and other foods for my infant based on the CACFP meal pattern.	
I will bring solid foods for my infant when s/he is ready for them.	

745 N. Negley Avenue • Pittsburgh, PA 15206 • P: 412-441-1868 • F: 412-441-1806

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement/Social Security/SSI/VA Benefits	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - ☐☐☐☐

Check if no SSN ☐

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	- A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits.
Income from person outside of household	- A friend or extended family member regularly gives a child spending money
Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) **If you are in the U.S. Military:** - Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) - Allowances for off-base housing, food, and clothing	- Unemployment benefits - Workers compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veterans benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private Pensions or disability benefits - Income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household