

**Waverly's Hope Child Care
5956 Colerain Avenue
Cincinnati, Ohio 45239
513-923-4673 (PH) 513-385-4673 (Fax)
Enrollment Packet
Waverlyshopechildcare.com
waverlyshopechildcare@gmail.com**

ELIGIBILITY DETERMINATION TIP SHEET
(WAVERLY'S HOPE)

10/21/2024



EHS-CCP SCHOLARSHIP BENEFITS

- FREE diapers, wipes & formula
- Child health screenings (speech, hearing, vision)
- Child developmental screenings
- Child assessment support
- Education Coach for your child's teacher
- Professional development trainings for teachers
- Family support services
- Classroom improvements
- Playground improvements

Step #1

Complete Pre-Application Form

- Parent(s), please complete the **ONLINE** 'Request for Service' form (scan camera over QR Code)
- Your application will be entered directly into our online record-keeping system.



CCP
Request for
Services
LINK



Head Start
Intake
Specialist
(Asia Hughes)

Step #2

Phone call to Start Application

Within 2 business days, Asia will text you to schedule a call.
Her number is: **513-346-8746**

**** Note: The EHS application must be completed to determine your child's eligibility and acceptance to receive an EHS-CCP Scholarship.**

Step #3

Documents to Submit for Eligibility

- After you speak with Asia, you will have **3 days** to complete the application:
- Send a copy of **child's birth certificate** (or crib card, shot record or child's medical insurance card) and **income docs** for the past 12 months.
- After **ALL required** documents have been submitted, reviewed and approved
- Your child will be enrolled in the EHS-CCP family!



Your CCP
Family Service
Worker:
Kellie Farley
513-978-4219

Step #4

Welcome! to the EHS-CCP FAMILY!!

- Once your child is enrolled in the EHS-CCP program ... your Family Service Worker will contact you. Kellie will work with you to finish your child's file.
- Also, Kellie will check in with you monthly, to provide assistance with your family needs, referrals & parent engagement opportunities.
- Please contact Madeline McSayles too, if you need anything or have questions.



CCP
Family Service
Manager,
Madeline McSayles
513-709-0517

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code	Home Telephone Number		
Parent/Guardian Name #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name		Name			
City		State	City		State
Telephone Number		Relationship to Child		Telephone Number	
				Relationship to Child	
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? *(check all that apply)*

No

Yes - *check all that apply* Food Medication Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? *(check one)*

No

Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? *(check one)*

No

Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? *(check one)*

No

Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? *(check one)*

No

Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

No

Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? *(check one)*

No

Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

No

Yes - written instructions from the child's health care provider must be on file.

N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or **medical personnel** in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Ohio Department of Job and Family Services
BASIC INFANT INFORMATION FOR CHILD CARE

<p>This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.</p>					
Child's Name			Nickname		
Child's Date of Birth			Siblings		
<p>What are you feeding your infant? <i>(Check all that apply)</i></p> <p><input type="checkbox"/> Formula (include brand) <input type="checkbox"/> Breast milk</p>					
Formula preparation <i>(if center/provider is to prepare.)</i>					
Amount for each feeding			Frequency of feedings		
<p>My infant likes a bottle warmed: <i>(Check one)</i> <input type="checkbox"/> Room temp <input type="checkbox"/> Warm <input type="checkbox"/> Very warm/NOT HOT</p>					
Juice <i>(type, amount, when?)</i>					
Does child use a cup yet? <input type="checkbox"/> No <input type="checkbox"/> Yes					
<p>Solid foods <i>(baby food, brand, types, amounts, frequency)</i> <i>*you must have written permission from your child's physician if your child is under 4 months and given solid foods.</i></p>					
Are foods served room temperature or warmed?					
Table food <i>(types, amounts, frequency, special instructions)</i>					
Security items <i>(pacifier, blankies, etc.)</i>					
Nap schedule					
Hints for getting baby to sleep					
<p>Sleeping Position <input type="checkbox"/> Back <input type="checkbox"/> Side* <input type="checkbox"/> Tummy*</p> <p><i>*You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.</i></p>					
Special Precautions					
Any additional information about your child that would be helpful or you would like staff to know.					
Parent Signature				Date	
Primary Caregiver Signature				Date	
Date form last updated					

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name <i>(Last)</i>	<i>(First)</i>	Nickname <i>(If any)</i>
<p><i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i></p>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. <i>(Check all that apply)</i> How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check all of the words that best describe your child's personality and behavior

- active adventurous affectionate anxious bossy bright busy calm cautious cheerful
 content creative curious easily-angered emotional energetic excitable friendly gives-in-easily
 happy hesitant insecure jealous likes structure/routines loud loving mellow outgoing
 prefers adult attention quiet sensitive serious shares-well social spontaneous stubborn tentative
 other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a high chair, booster, child size chair or adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date

Ohio Department of Job and Family Services
CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? Yes (If Yes, complete Part II) No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight (if needed to determine dosage)
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Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
---------------------------------	---------------------------------	---------------------------------

Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
-----------------------------------	-----------------------------------	-----------------------------------

Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
--	--	--

Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date
---	---	---

Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date
---	---	---

Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature
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Part III: Administration of Medication or Medical Food Training Authorization
Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)

Part III must be completed

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? (Check all that apply)

Medication Supplies Assistance N/A

Parent Provided Training AND grants permission to perform the procedure	Complete Only One Section	Certified Professional Training AND parent grants permission to perform the procedure
<i>My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>		<i>My signature indicates I have provided instructions for care and/or training for the medical procedure</i>
Parent Signature		Certified Professional's Name (please print)
Date of Signature		Certified Professional's Signature
		Date of Signature Phone Number
		<i>My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>
	Parent Signature	
	Date of Signature	

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the procedure for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
<i>My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.</i>	Administrator/Provider Signature	Date of Signature

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

CHILD AND ADULT CARE FOOD PROGRAM INFANT MEALS – PARENT PREFERENCE LETTER

TO: Parents and Guardians of Infants under one year of age

FROM:

NAME OF CENTER/PROVIDER	
-------------------------	--

TOPIC: Who will provide food for your infant's meals?

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a U.S. Department of Agriculture (USDA) child nutrition program. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

NAME OF FORMULA	
-----------------	--

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section. **When a child is developmentally ready, parents can provide only one component (food or formula) as part of a reimbursable meal or snack.**

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

- I want the center or FCC home provider to provide formula for my infant
- I will bring iron fortified infant formula for my infant
- I will bring expressed breast milk for my infant
- I will come to the center or FCC home to breast feed my infant

Parent/Guardian: List Name of Formula You Will Provide
--

Solid Food: (check one)

- I want the center or FCC home to provide all solid foods for my infant when he/she is developmentally ready
- I will bring one solid food item for my infant when he/she is developmentally ready for it and the center will provide all other required components including formula.

***Note: If your feeding preferences change, you will be asked to complete a new form.**

INFANT NAME:	INFANT BIRTHDATE:
PARENT/GUARDIAN SIGNATURE:	DATE:

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410;
2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

Ohio Department of Education and Workforce - Office of Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be completed annually and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME
(please print)

AGE

BIRTHDATE

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

**SIGNATURE OF
PARENT/GUARDIAN**

DATE

**DAY PHONE
NUMBER**

**MAILING ADDRESS
STREET /APT.**

CITY

ZIP CODE

PARENT BIRTHDATE month / day / year

PARENT EMAIL

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

Revised 8/2025

Sample Form

Ohio Department of Education and Workforce - Office of Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

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- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME Waverly's Hope Child Care

CHILD'S NAME (please print) Sammy Smith **AGE** 1 month **BIRTHDATE** 1 / 12 / 26
month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
 AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday ✓	7:30	4:00			✓	✓	✓			
Tuesday ✓	7:30	4:00			✓	✓	✓			
Wednesday ✓	7:30	4:00			✓	✓	✓			
Thursday ✓	7:30	4:00			✓	✓	✓			
Friday ✓	7:30	4:00			✓	✓	✓			
Saturday										
Sunday										

Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

SIGNATURE OF PARENT/GUARDIAN  **DATE** 2/1/26 **DAY PHONE NUMBER** 513-123-4567

MAILING ADDRESS STREET /APT. 123 Home Rd **CITY** Cincinnati **ZIP CODE** 45239

PARENT BIRTHDATE 3 / 10 / 80 **PARENT EMAIL**

month / day / year

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2. Fax: (202) 690-7442; or
3. Email: program.intake@usda.gov.

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2025-2026

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4*, an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. The form must be completed annually and valid for only 12 months.

CENTER NAME			CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation)	PART 2 – LIST EACH CHILD’S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.	
PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER				Check type of benefit:	<input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE		CASE NO.	_____
1.			<input type="checkbox"/>	CASE NO.	_____
2.			<input type="checkbox"/>	CASE NO.	_____
3.			<input type="checkbox"/>	CASE NO.	_____
4.			<input type="checkbox"/>	CASE NO.	_____

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH		\$ amount / how often	\$ amount / how often	\$ amount / how often	\$ amount / how often
1.		\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.		\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.		\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.		\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.		\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.		\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the “I do not have a Social Security Number” box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:
		<input type="checkbox"/> I do not have a Social Security Number

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other
Please mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		

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. **State Distribution: July 2025**

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion: Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12	Application Certified/Categorized as: <input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household size and income <input type="checkbox"/> Foster Child <input type="checkbox"/> REDUCED-PRICE, based on Household size and income <input type="checkbox"/> PAID, based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information
Total Household Size: _____	Total Household Income: \$ _____ Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year

Signature of Sponsor / Center Representative _____ Date Sponsor Certified/Categorized Form _____ Effective Date _____ Expiration Date _____
 Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. (From the first of month of date signed) (Valid until last day of month in which form was signed one year earlier)
 If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

ETHNIC and RACIAL DATA FORM

Agency/Daycare Center _____

Agency/Daycare Address _____

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

Child's name _____

Ethnic Category: Choose one _____

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
Non-Hispanic or Latino:	

Racial Categories: Check all that apply

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: A person having origins in any of the black racial groups of Africa.	
Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
Other	

Parent/Guardian Signature _____ Date _____

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***Waverly's Hope Child Care LLC
Enrollment Daily Schedule***

In effort to provide children in our care with quality care, we are requesting your child's schedule. Please fill in the information below regarding the times that your child will be in our care. We provide all full-time children with a maximum of ten (10) hours per day. Once this schedule is set your child will not be permitted to arrive earlier than the agreed upon time. Your child will also not be permitted to be picked up after the agreed upon time. Parents that arrive after the agreed upon time will receive a late fee of \$5 per minute per child. The late fee must be paid upon drop off the next day.

Enrolled Child's Name:
Parents Name:
Drop Off Time:
Pick Up Time:
Parent Signature:
Date:

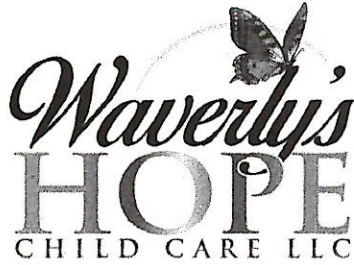


Photo & Video Release Form

Child's Name: _____

Parent/Guardian Name: _____

Date: _____

At *Waverly's Hope Child Care LLC*, we occasionally take photographs and videos of the children during daily activities, classroom projects, and special events. These images may be used for:

- Classroom displays
- Newsletters
- Marketing materials
- Our website
- Social media (e.g., Facebook, Instagram)
- Educational documentation

Please indicate your preference below:

I GIVE permission for my child to be photographed and/or video recorded by *Waverly's Hope Child Care LLC* for the purposes listed above. I understand that these images may appear in both print and digital formats.

I DO NOT GIVE permission for my child to be photographed or video recorded.

I also understand that my child's full name will **not** be used in any public materials without additional written consent.

Parent/Guardian Signature: _____

Date: _____

Good nutrition today means a stronger tomorrow!

Building for the Future

with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.



Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

[Here is space for the State agency and sponsoring organization to add contact information]

Learn more about CACFP at USDA's website:

<https://www.fns.usda.gov/>

USDA is an equal opportunity provider, employer and lender.

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

¡Buena nutrición hoy significa un mañana más saludable!

Construyendo para el Futuro

con CACFP

Esta guardería infantil
recibe ayuda del
Child and Adult Care
Food Program para
servir comidas
nutritivas a sus niños.



**Comidas servidas aquí deben de seguir los
requisitos nutricionales establecidos por USDA.**

¿Preguntas? ¿Inquietudes?

[Here is space for the State agency and sponsoring organization to add contact information]

Aprenda más información sobre CACFP en el sitio web del
USDA: <https://www.fns.usda.gov/>

USDA es un proveedor, empleador y prestamista que ofrece igualdad de oportunidades.

United States Department of Agriculture
Food and Nutrition Service FNS-317
Noviembre 2019

Building for the Future

This childcare 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 millions of children participate in CACFP at childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals which 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 five components)
Milk Fruit OR Vegetable Grains or Bread* *Meat/Meat Alternate may replace entire grain up to 3x/week	Milk Meat or meat alternate Grains or bread Vegetable AND Fruit or Second Vegetable (If serving two vegetables they must be different foods)	Milk Meat or meat alternate Grains or bread Fruit 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 childcare centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes:** Licensed private homes.
- **After School Care Programs:** Centers in low-income areas provide free snack and/or meal 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 aged 12 and under,
- Migrant children aged 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

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

Sponsoring Organization/Center

<p>Waverly's Hope Child Care 5956 Colerain Avenue Cincinnati, OH 45239 Phone: 513-923-4673</p>
--

Ohio Department of Education and Workforce

<p>CACFP Program Specialist 25 S. Front Street, MS 303 Columbus, OH 43215-4183 Phone: 614-466-2945 Toll Free: 1-800-808-6235</p>
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Nondiscrimination: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

2. fax:

(833) 256-1665 or (202) 690-7442; or

3. email: Program.Intake@usda.gov

This institution is an equal opportunity provider.

Ohio Department of Children and Youth
FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

<p>We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL</p> <p>Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.</p>			
Child's/Children's Name(s):		Caretaker's Name:	Date Completed:
TOPICS		Briefly List CONCERN	
Child Development and Education - Does anyone in your family have any need for resources or support in the areas listed below?			
Y	N	Information on child growth and development.	
Y	N	Guiding and supporting a child's behavior.	
Y	N	Medical or disabilities or possible conditions for any child or adult in the family.	
Y	N	Obtaining toys or activities to use to help any child in your home.	
Y	N	Preparing your child for kindergarten.	
Child and Family Health - Does anyone in your family have any need for resources or support in the areas listed below?			
Y	N	Health insurance and/or access to regular medical care, dental care, or medications.	
Y	N	Medical or health supplies or supports that anyone in your family needs.	
Y	N	Accessing immunizations.	
Y	N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.	
Y	N	Concerns with depression, anger, anxiety, or mental health needs.	
Y	N	Concerns with alcohol, drug, or addiction problems.	
Financial and Household Supports - Does anyone in your family have any need for resources or support in the areas listed below?			
Y	N	Help paying for child care.	
Y	N	Help finding housing or safe housing.	
Y	N	Help paying your mortgage or rent.	
Y	N	Help with food expenses.	
Y	N	Finding household items such as furniture, clothing, or school supplies.	
Y	N	Access to transportation or transportation expenses.	
Y	N	Attending school (such as a GED, Certifications, or college degrees)	
Y	N	Help finding work or job training	

Are there other needs you or your family have that are not listed above:

Parent Signature	Date:
Administrator or Designee Signature:	Date:

For Staff Use:

Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
	Referrals provided to the family:	Referrals provided to the family:
	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
		Follow-up provided to the family:
		Administrator or Designee Signature & Date:



Waverly's Hope Child Care 2026 Closure Days (6 professional development days)

Holiday*	2026
New Year Day	Thursday, Jan 1
Martin Luther King Jr Day	Monday, Jan 19
Presidents Day	Monday, Feb 16
Memorial Day	Monday, May 25
Juneteenth National Independence Day	Friday, June 19
Independence Day	Friday, July 3
Labor Day	Monday, Sept 7
Columbus Day	Monday, Oct 12
Veteran's Day	Wednesday, Nov 11
Thanksgiving Day & Black Friday	Thursday/Friday, Nov 26 & 27
Christmas Eve & Christmas Day	Thursday/ Friday Dec 24 & 25
New Year's Eve/ New Year's Day	Thursday/ Friday Dec 31 & Jan 1



Ohio WIC Program Eligibility

Who is eligible?

Pregnant and breastfeeding women; women who recently had a baby; infants birth through 12 months; children age 1 to 5 years; who are:

- Present at the clinic appointment, and provide proof of identity.
- Residents of the State of Ohio.
- Determined by health professionals to be at medical/nutritional risk.
- Meets income guidelines - 185% of Federal Poverty Income Guidelines.

Ohio WIC Program Income Guidelines

In order to be eligible for WIC, the gross countable income of the economic unit, of which the applicant/participant is a member, must be less than or equal to the Ohio WIC program income guidelines for economic unit size provided in the following chart. WIC income guidelines are updated each year.

Economic Unit	Annually	Monthly	Twice Monthly	Biweekly	Weekly
1	\$28,953	\$2,413	\$1,207	\$1,114	\$557
2	\$39,128	\$3,261	\$1,631	\$1,505	\$753
3	\$49,303	\$4,109	\$2,055	\$1,897	\$949
4	\$59,478	\$4,957	\$2,479	\$2,288	\$1,144
5	\$69,653	\$5,805	\$2,903	\$2,679	\$1,340

6	\$79,828	\$6,653	\$3,327	\$3,071	\$1,536
7	\$90,003	\$7,501	\$3,751	\$3,462	\$1,731
8	\$100,178	\$8,349	\$4,175	\$3,853	\$1,927

Revised 7/25

How to Apply

WIC clinics are located in all 88 Ohio counties. Applicants can call the Help Me Grow Helpline at **1-800-755-GROW (1-800-755-4769)** for specific clinic locations or call your county WIC clinic ([see Clinic Directory for your county WIC clinic phone number](#)).

You can also apply by printing out a [Ohio Women, Infants, and Children \(WIC\) Program Application \(Solicitud del Programa de WIC\)](#) and mailing it to the WIC clinic in your area. Please note that you must schedule an appointment at the clinic, too.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and 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, etc.), 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.

Complaints

Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations

and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

If you have difficulty communicating with us because you do not speak English or if you have a disability and need assistance, free language assistance and other aids and services are available. Individuals with speech or hearing disabilities that require language and communication assistance may contact the State Relay Number 711 or (800) 750-0750 Voice/TTY, or (877) 750-9097 Speech-to-Speech or (888) 269-0678 for Spanish. For additional language interpretation or translation assistance, please contact the Ohio WIC Program at (614) 644-8006.

ohiorelay.com

What Do I Bring to My First Visit?

- ♥ Proof of income (current pay stubs, approval letter for Healthy Start, Ohio Works First, Food Stamps or current Medicaid card)
- ♥ Proof of address (utility or credit bill, or Ohio driver's license)
- ♥ Proof of identity for you and any other applicants (birth certificate, driver's license, Medicaid card, crib card or shot record)
- ♥ All family members applying for WIC services
- ♥ If pregnant, a doctor's statement showing due date
- ♥ Children's shot records



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 Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

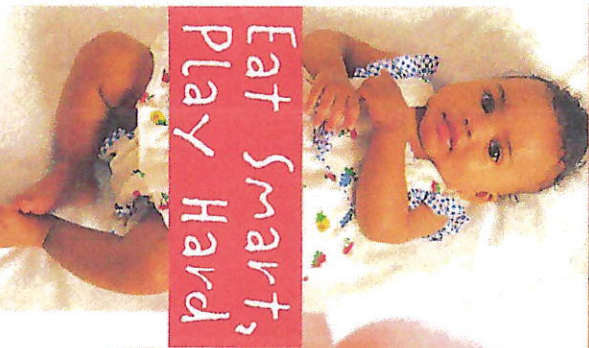
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The mission of the WIC program is to improve the health status and prevent health problems among Ohio's at-risk women, infants and children.

Visit our Web site: <http://www.odh.ohio.gov>

07/04/13



What is WIC?

WIC is a nutrition education program. WIC provides nutritious foods that promote good health for pregnant women, women who just had a baby, breastfeeding moms, infants and children up to age 5.



Who is Eligible for WIC?



Women who are pregnant, breastfeeding or have a baby less than 6 months old, and infants and children up to 5 years old are eligible to apply for WIC. Fathers are welcome to apply for WIC for their children up to age 5.

To qualify for services you must:

- ♥ Live in Ohio
- ♥ Meet WIC income guidelines
- ♥ Have certain nutritional or health risks

What Does WIC Provide?

- ♥ Nutrition education and support
- ♥ Breastfeeding education and support
- ♥ Referral for health care
- ♥ Immunization screening and referral
- ♥ Supplemental foods such as:



- Cereal
- Eggs
- Milk
- Whole-grain foods
- Fruits and Vegetables
- Infant formula



How Do I Apply?

Make an appointment

Call your local clinic to schedule an appointment to meet with a WIC staff member or call **1-800-755-GROW (4769)** for locations and more information.

See if you qualify

All it takes is a visit to your local WIC clinic to see if you qualify for services.



Receive WIC coupons
If you are eligible, you will receive coupons to buy healthy foods at local WIC-approved grocery stores.





Waverly's Hope
Parent Handbook Agreement

I _____ parent of _____ have received, reviewed, understand the policies of Waverly's Hope Child Care LLC per the Parent Handbook.

 Parent Signature

 Parent Name

 Date



Please check this box to confirm that you received resources via email with this handbook from Waverly's Hope Child Care.