

2019-20 School Year
Application for the
EPS PK STEAM Academy
Stowe Early Learning Center
117 Post Office Road
Enfield, CT 06082
860-253-4741

The **EPS PK STEAM Academy** at Stowe Early Learning Center is a pre-kindergarten opportunity for **Enfield students who will be four years of age by December 31, 2019**. The program meets five days a week, follows the regular school calendar, and is a full-day program. The school day begins at 9:05 and ends at 3:31. Breakfast, lunch, and snack are provided. This NAEYC-accredited program operates based upon the Connecticut Early Learning and Development Standards and the Enfield Board of Education's approved preschool curriculum.

Online submissions and mailed applications must be received by March 15, 2019. The lottery will be drawn on March 18, 2019, and families will be notified by March 29, 2019.

TRANSPORTATION IS NOT PROVIDED FOR THIS PROGRAM.

For more information, please contact Jaclyn Valley, PK STEAM Academy Coordinator at 860-253-5320 or at jvalley@enfieldschools.org.

You may submit this form by cutting along the dotted line and returning to **EPS PK STEAM Academy, Stowe Early Learning Center, 117 Post Office Rd, Enfield, CT 06082**.

PLEASE PRINT

Child's Name _____ Date of Birth: _____
(First Name) (Middle Name) (Last Name)

Street Address: _____

City/Town: _____

Parent/Guardian Name: _____

Telephone Number: _____
(Home) (Mobile)

Email Address: _____

Has your child received or is your child receiving special education services? (i.e. OT/PT, Speech) Yes _____ No _____

What is the primary language spoken at home? _____

Do you think you are eligible for Free or Reduced lunch? Yes _____ No _____

******All applicants, whether checking yes or no to the above question, are required to complete the accompanying lunch application form. If submitting online, please mail or drop off the lunch application form to the school at the above address.**

Child and Adult Care Food Program (CACFP)

INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS AND HEAD START

For instructions, see *Instructions for Income Eligibility Application for Child Care Centers and Head Start*.

PART 1 — CHILD'S INFORMATION

Child's Name: _____ Age: _____ Birth Date (month, day, year): _____

Child's Normal Child Care Schedule (Check all days that apply):

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Child's Normal Hours of Care (Include time and circle AM or PM):

_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM

Normal Meal Services Provided to Child (Check all meals/snacks that apply):

Breakfast A.M. Snack Lunch P.M. Snack Supper

PART 2A — PARTICIPANTS CATEGORICALLY ELIGIBLE AS FREE FOR CACFP BENEFITS

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children. Complete this part and part 3. Do not complete part 2B.

SNAP Case Number: _____ TFA Case Number: _____ Check if foster child:

PART 2B — ALL OTHER HOUSEHOLDS

If you did not complete part 2A, complete this part and part 3.

Names of all household members <i>List everyone in the household, including the child listed in part 1 above.</i>	Gross income and how often it was received: Indicate if income was received monthly, two times a month, every two weeks or weekly by placing the amount of income in the appropriate frequency box. You must place the income in the appropriate frequency box.											
	Earnings from Work (before deductions) – Job 1				Public Assistance/ Alimony/Child Support				Pensions/Retirement/Social Security/All Other Income			
	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	\$200					\$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

PART 3 — CONTACT INFORMATION, SIGNATURE AND SOCIAL SECURITY NUMBER

An adult household member must sign and date this form before it can be approved.

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed Name of Adult: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX-_____ I do not have a SSN

Home Telephone: _____ Work Telephone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

CACFP INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS AND HEAD START, continued

PART 4 — RACIAL AND ETHNIC IDENTITY (OPTIONAL) *You are not required to complete this part.*

Ethnicity (Check one):

- Hispanic/ Latino
 Not Hispanic/Latino

Race (Check one or more):

- Asian
 White
 Black or African American

- American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander

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 your child 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 last four digits of 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 or other FDPIR identifier for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
 Office of the Assistant Secretary for Civil Rights
 1400 Independence Avenue, SW
 Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

FOR SPONSOR USE ONLY – DO NOT WRITE BELOW THIS LINE

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

Total family income: \$ _____ Family size: _____ OR SNAP/TEA household Foster Child

Eligible Free Eligible Reduced Over Income

Sponsor Eligibility Official: _____ Date: _____
Signature



For information on the CACFP, visit the CSDE's CACFP website or contact the CACFP staff in the Connecticut State Department of Education, Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103.

This form is available at www.sde.ct.gov/sde/lib/sde/pdf/deps/nutrition/cacfp/forms/ieappcenter.pdf.