ALPHA SCHOOL, INC.

Alpha School – Alpha Tots – Alpha Babies

Dear Parents,

Enclosed you will find a copy of the **2023- 2024** Alpha School Registration Materials.

Please return the following items with your registration:

- A completed Application Form
- A completed Admission Record Form
- A completed Physician's Statement
- A copy of Immunization Records
- Permission for Sunscreen, Insect Repellant & Photographs
- A Child Information Sheet
- A completed CACFP / Income Eligibility Form
- CACFP Enrollment Information Form
- A signed Parent Handbook Form ***(*During Parent/Teacher Conference)***
- A $100 Registration Fee is Required ***(New Families Only)***

Your enrollment will be complete *only* after returning a COMPLETED PACKET (ALL FORMS). You will receive your ***Parent Handbook*** and ***School Calendar*** at Open House.

Thank you,

Ray Jaramillo –Owner/Director
jaramilloray1@yahoo.com
575-527-1313

Barbara DeDera –Director
alphaschool@zianet.com

ALPHA SCHOOL, INC.

Application Form June 2023 – May 2024

Child's Name _____

Parent's Name _____

Address _____

_____

Home Telephone (575) _____ Cell (_____)_____

Child's Birth Date _____/_____/_____ Age of Child_____

STATEMENT OF INTENT

Please circle your child's class

Alpha Babies/Tots/School:

Infant **Mobile Infant** **Young Toddler**

I intend to enroll my child in Alpha School Inc., for the school year:

JUNE 2023 THROUGH MAY 2024

Or upon termination by either party

A Registration Fee is required ***(New Families Only)*** and must accompany this application. The Fee is $100.00 (per family) and will hold your child's place in our program.

This Fee is Non-Refundable This Fee is Non-Refundable

1205 E. Madrid Ave., Las Cruces, NM 88001 / (575) 527-1313

Admission Record

TO BE COMPLETED BY PARENT, GUARDIAN, OR OTHER RESPONSIBLE PERSON

Child's Name _____

Home Address _____ Zip Code _____

Home Number ( ) _____ Gender Male Female *please circle*

Child's Birth Date | Month | Day | Year | Age of Child _____

Parent Name _____ Parent Name _____

Social Security # Required _____ *Social Security #* Required _____

Employer _____ *Employer* _____

Work Phone# _____ *Work Phone#* _____

Cell Phone # ( ) - _____ *Cell Phone #* ( ) - _____

E-mail Address _____ *E-mail Address* _____

Allergies / Medical Condition ***Must be accompanied by a physician statement - Thank you***

EMERGENCY CONTACTS **Other Than Parents**

Emergency Contact # 1

Name _____

Home/Wk. Phone _____

Cell Number _____

Emergency Contact # 2

Name _____

Home/Wk. Phone _____

Cell Number _____

Emergency Contact # 3

Name _____

Home/Wk. Phone _____

Cell Number _____

Authorized Pick- Up (list Names)

1

2

3

4

Family Doctor: _____

Family Dentist: _____

Family Hospital ***(circle one)***

Memorial Medical Center Mountain View Hospital

PARENTS MUST SIGN AND DATE:

Consent for Emergency Treatment

I give permission for my child to be transported by ambulance, aid car, or staff car to an emergency center for treatment. In the event that I cannot by contacted, I further consent to the medical, surgical, and hospital care treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately or advisable by the physician to safeguard my child's health. I agree to pay all costs of transportation and emergency medical treatment.

Parent Signature _____ Date _____

Date of Enrollment _____ *Date of Disenrollment* _____

Alpha School Inc
1205 E. Madrid Ave
Las Cruces, NM 88001

575-527-1313

Physician Statement:

The physician must complete this Portion.

DPT:

		Date
#1	2 Months	
#2	4 Months	
#3	6 Months	
#4	15-18 Months	

Polio:

		Date
#1	2 Months	
#2	4 Months	
#3	15-18 Months	
#4	4-6 years	

PPD: Date _____

Results:

HEP:

		Date
#1	At Birth	
#2	1-2 Months	
#3	6-18 Months	

HIB:

		Date
#1	2 Months	
#2	4 Months	
#19	After 15 months	

MMR:

#1	
#2	

	Date	Results
Dental Screening		
Hearing Screening		
Vision Screening		

Any allergies or special consideration / recommendations:

Height	
Weight	

Physician Name _____

Telephone Number _____

Address _____

Date _____

I hereby certify that_____(child's name) has been examined by me and is physically and mentally capable of attending and participating in the activities at Alpha School Inc.

Physician's Signature_____

ALPHA SCHOOL, INC.

Child's Name_____

Date: _____/_____/ _____

Parental Permission for Sunscreen and Insect Repellant:

The National Academy requires children to be protected from the sun by using sunscreen or sunblock with UVB and UVA protection of SPF 15 or higher applied to exposed skin. Also, when public health authorities recommend using insect repellents due to the high risk of insect-borne diseases, only repellents containing DEET are used and applied to children older than two months.

My Child has permission to have sunscreen & insect repellent applied when needed.

Parent(s) Signature_____

Permission to Photograph

I permit Alpha School Inc. to photograph my child. I understand these pictures are for Alpha School use only and will not be made public without written consent. Alpha School will only use them for portfolios, crafts, and classroom decoration.

Parent(s) Signature_____

1205 E. Madrid Ave., Las Cruces, NM 88001 / (575) 527-1313

CHILD INFORMATION SHEET

Child's Name_____

Language spoken at home_____

Brothers / Sisters_____Ages_____

Other adults in home_____Pets_____

Other group experiences_____

_____

Describe your child's personality_____

_____

_____

Any fears, anxieties_____

_____

Parents, do you have any special talents?? Can you help on field trips or parties??_____

Infants / Toddlers

Please tell us about the following:

Your child's birth: _____

_____

Eating patterns: _____

_____

Sleeping patterns: _____

_____

How does your child like to be comforted? _____

_____

How did you hear about Alpha School?

_____

Child and Adult Care Food Program
LETTER TO HOUSEHOLDS

New Mexico Early Childhood Education & Care Department

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
Alpha School for Young Children, Inc.	13007	575, 527, 1313

Instructions: This letter must accompany the Income Eligibility Application.

Dear Parent / Guardian or CACFP Participant:

Alpha School for Young Children, Inc. Participates in the Child and Adult Care Food Program (CACFP) administered by the United States
Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial)

Department of Agriculture. Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary to decide the level of CACFP reimbursement your center is eligible to receive for the meals served to children and/or adult participants in our program. This form will be treated as confidential information. All participants in our program receive their meal free of charge, but the determination of eligibility category affects the amount of federal funding we receive. Foster Children: A foster child enrolled in our program that is the legal responsibility of a welfare agency, or court may be certified as eligible for free meals regardless of your household income. Please refer to the instructions on how to complete the Income Eligibility Application form.

SNAP - Supplemental Nutrition Assistance Program (formerly the Food Stamp Program): If your household is currently receiving benefits under the Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservations (FDPIR) and your child is enrolled in a child care center you need only to list the case number sign and date the form.

If your household is receiving benefits under the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Medicaid or Food Distribution Program on Indian Reservations (FDPIR) and an adult in your home is enrolled in an Adult Daycare Center then you need only to list their case number sign and date the form. Otherwise, an adult household member must complete the form and disclose total current household income by source, and the names of all household members. The person completing the form must sign, provide a social security number, and date when completed.

The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide your annual income, or you may use last year's income if no significant changes have occurred. If your households' income is equal to or less than the amounts indicated for your households' size on the chart below, your provider may qualify for maximum reimbursement rates. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses).

INCOME ELIGIBILITY GUIDELINES - (EFFECTIVE FROM JULY 1, 2022 TO JUNE 30, 2023)

	FREE			REDUCED		
HOUSEHOLD SIZE	YEAR	MONTH	WEEK	YEAR	MONTH	WEEK
1	17,667	1,473	340	25,142	2,096	484
2	23,803	1,984	458	33,874	2,823	652
3	29,939	2,495	576	42,606	3,551	820
4	36,075	3,007	694	51,338	4,279	988
5	42,211	3,518	812	60,070	5,006	1,156
6	48,347	4,029	930	68,802	5,734	1,324
7	54,483	4,541	1,048	77,534	6,462	1,492
8	60,619	5,052	1,166	86,266	7,189	1,659
	6,136	512	118	8,732	728	168

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: How to File a 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: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Ray Jaramillo		
Name of Sponsor / Center Representative	Signature of Sponsor / Center Representative	Date

Child and Adult Care Food Program
INSTRUCTIONS FOR COMPLETING THE INCOME ELIGIBILITY FORM

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
Alpha School for Young Children, Inc.	13007	(575) 527 / 1313

PARTICIPANT INFORMATION:

List name of all enrolled participants that you are applying for which are in care.

List each enrolled participant's date of birth.

If you are applying for a foster child, list only one foster child per form. A foster child may be eligible for free meals regardless of household income.

Child Care Centers: If the participant enrolled is in a Child Care Center and receives benefits through Supplemental Nutrition Assistance (SNAP), (*formerly food stamps or Food Distribution Program on Indian Reservation (FDPIR)*, please indicate the appropriate **case number** in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

Adult Day Care Centers: If the participant enrolled is in an Adult Daycare Center and receives benefits thru Supplemental Nutrition Assistance (SNAP) formerly, food stamps, Food Distribution Program on Indian Reservation (FDPIR), Supplemental Security Income (SSI) or Medicaid, please indicate the appropriate **case number** in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

If you do not receive benefits and have no case number for participants enrolled at the center, you must complete all parts of the IEA (Household and Income information).

HOUSEHOLD AND INCOME INFORMATION

Not required to be completed if case# is provided above.

List all household members. A household is a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses).

Provide the most current income by source for all household members. This can be based on the most recent information the month prior to completing the application.

Reported income needs to be reported on the same. The income reported on the application must include all income before taxes and before other deductions.

A foster child, defined as a ward of the court or welfare agency. Only the foster child's "personal use" income is listed.

Personal use income includes:

- Funds that are specified by the welfare agency as being for the personal use of the child. (If no funds are specified, the funds received from the welfare agency are not to be considered as income. Record "0" on personal income.)
- Money received from any source. This includes, but is not limited to, funds received from trust accounts, from the child's family, and earnings from the child's employment other than occasional or part-time jobs.

SIGNATURE

The adult family member completing the application must sign and date the application.

If the enrolled participant is not a recipient of benefits and has not provided a case number, the adult family member signing the application must provide a social security number.

If you do not have a social security number, check the "box" provided. Otherwise, failure to provide the social security number (if you have one) will make the Income Eligibility Application invalid and will reduce the level of CACFP reimbursement your family's Child Care Center receives for meals served to the children and/or adult participants enrolled for care in their center.

Child and Adult Care Food Program
INCOME ELIGIBILITY APPLICATION

New Mexico Early Childhood Education & Care Department

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
Alpha School for Young Children, Inc.	13007	(575) 527 / 1313

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.

Instructions: Complete this form and return to the Facility / Center / Site / Home Provider

ENROLLED PARTICIPANT INFORMATION:

(Check if applicable for Enrolled Participant)

Case #:

First:	Last:	DOB:	Child Care Centers:	Adult Daycare Centers:
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐
			☐ Foster Child? ☐ SNAP ☐ FDPIR	☐ SSI ☐

If Enrolled Participant is a Foster Child: Please list the amount of the child's "personal use" monthly income (if no personal income, record "0"): _____

HOUSEHOLD INFORMATION:

List the first and last name of each person living in the household, related or not (such as grandparents, other relatives, or friends who live in the household). (Please use additional forms if more lines are required).

First:	Last:	First:	Last:

Total Number in Household: _____

HOUSEHOLD INCOME: Please indicate source and amount of current income for all members of your household. Please follow the definition of income specified in the standards for determining free and reduced-price eligibility in your parent letter. If you receive more than one check from any of these sources, please indicate the total ***monthly*** amount received.

Wages / Salary: $ _____ Child Support: $ _____ Social Security: $ _____ Pension/Retirement: $ _____

Unemployment: $ _____ Other Income: $ _____ **Total Income**: $ _____ ☐ Monthly

PENALTIES FOR MISREPRESENTATION: I certify that all the above information is true and correct and that the food stamp or FDPIR number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

_____ Signature of Adult Family Member

Last Four Digits of Social Security Number* ☐ Check if no SS#

Date

Privacy Act Statement:

This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires that, unless the participant's food stamp or FDPIR number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of the information on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or FDPIR office to determine current certification for receipt of SNAP (food stamp) or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

FOR SPONSOR'S USE ONLY

☐ Child Day Care Center ☐ Adult Day Care Center ☐ Approved Free ☐ Approved Reduced ☐ Paid

☐ Home Provider Tier I Eligibility Verified by: ☐ Tax Return ☐ W-2 ☐ Pay Stubs ☐ Other Date Verified: _____

☐ Home Provider Child(ren) Tier I Eligibility Verified by: ☐ Household Income ☐ Categorically Eligible School Name / District: _____

☐ Home Provider or Child(ren) TIER I Ineligible

_____ Signature of Facility / Center / Site Representative / Home Provider

Alpha School for Young Children, Inc. Name of Facility / Center / Site Representative / Home Provider

Approving Date

Date Disenrolled

* Complete Social Security Number is not required for CACFP Participation, only the last four digits are required.