FREE PROGRAM TO **ELIGIBLE** 3 or 4-YEAR OLD CHILDREN IN LAS CRUCES

Our program accepts enrollees from Title 1 schools within the Las Cruces Public School district

MONDAY – FRIDAY 8:30 AM TO 2:00 PM 575-523-1616

STUDENT MEALS

Our program provides children with a nutritious breakfast, lunch, and snack at no cost to families. Meal time is a perfect learning opportunity, and teachers use this time to teach skills and to reinforce healthy eating habits.

FAMILY ENGAGEMENT

Family engagement is an essential component of our programs. Our PreK supports parents/families as their child's first and most important teacher. We have developed a Family Engagement Plan which provides 90 hours of engagement activities throughout the school year. Families are invited to participate in all our events.

Health Screenings/ Developmental Screenings

Each child in the PreK program must receive the following health screenings by a school health care professional prior to the beginning of the program or within the first three months of attendance:

- ✓ physical examination
- ✓ current immunization

Additional screenings include hearing, vision, dental and ASQ which will be completed at our facility at no cost to families.

Ashley's Garden is a five-star program that focuses on child development, growth and learning to provide the greatest opportunity for success in kindergarten and later school years. Our Montessori-based curriculum utilizes a multi-sensory approach to learning—incorporating a comprehensive array of integrative movement activities and special programs which support NM PreK Early Learning Outcomes. We support the full participation of every child through curriculum components that address dual language learners while exposing the children to sign language and various cultures from the world. The curriculum is theme-based with emphasis on learning through play and the development of positive social relationships, which leads to the development of academic skills. Families, who are children's first and most important teachers, are encouraged to participate in our program through an extensive list of activities. Our PreK programs are based on attendance and family involvement.

PreK ensures that every child in New Mexico has the opportunity to attend a high-quality, early childhood education program before entering kindergarten. The purpose of New Mexico PreK is to:

- increase access to voluntary high-quality pre-kindergarten programs;
- provide developmentally appropriate activities for New Mexico children;
- expand access to early childhood programs across New Mexico;
- support linguistically and culturally appropriate curriculum; and
- develop school readiness in those served.

PreK teachers carefully plan indoor and outdoor activities based on what children are required to learn in the following areas:

- listening, language, reading, and writing
- science
- counting, shapes, sorting, and measuring
- coordination, hygiene, health, and well-being
- art, music, and movement
- independence, problem-solving, thinking, and perseverance
- appropriate behavior, social skills, and being part of a group

Gym Magic KIDS

ASHLEY'S GARDEN PREK & EARLY PREK REGISTRATION FORM

Start/end date of classes will be announced after Las Cruces Public Schools release the 2020 - 2021 calendar. Program times are Monday through Friday – 8:30 am to 2:00 pm. **Required:** Parent participation in student activities/project; parent meeting in July; parent-teacher conferences three times a year; and, attendance.

An after-hours care program (Little Campers) is available Monday – Friday (7:45 am – 8:15 am and 2:00 pm to 5:30 pm) for those who need extended hours. State subsidies are accepted.

Children must have reached their 3rd or 4th birthday before 12:01 am September 1 of the current year.

ENROLLMENT PRIORITIES

1. Children who reside in Hermosa Heights Elementary School district.
2. Children who reside in Title I school districts. (Check LCPS website.)
3. Children who would not have an opportunity to attend a high-quality preschool.

WAITING LIST

Once capacity has been reached, children will be placed on a waiting list. As a spot opens, children will be chosen using the above criteria, based on enrollment application date.

ATTENDANCE POLICY

Parents must agree to a 95% attendance rate. Excused absences must have written doctor's excuse. Three days of unexcused absences = warning. Five days of unexcused absences = 2nd warning. Seven days of unexcused absences = dismissal from program. **Late arrivals/early dismissals count as absences.**

The following is required for registration:

- Completed application form
- Proof of date of birth
- 1 Copy of Immunization Record Signed by a physician
- Religious or medical exemptions to these requirements must be submitted to school officials in writing by State of New Mexico Health Department
- 1 copy of residency proof (current utility bills, mortgage commitment on existing residence only)
- Custody papers (if applicable)
- Copy of the (IEPs) if applicable
- Signed permission for screenings: dental, hearing, vision, ASQ screenings

FOR OFFICE USE ONLY

Date Received:_____Initials _____
Age Eligible:_____Birth Certificate____ Passport____
Hermosa Heights District: _____
Title 1 school: _____
Income Eligible: _____

ASHLEY'S GARDEN PreK & Early Prek 2020-2021

PART 1: PERSONAL INFORMATION

CHILD'S NAME:_____
LAST FIRST MIDDLE INTIAL

DATE OF BIRTH:_____ SEX: □ Male □Female AGE:____years____months
MONTH / DAY / YEAR

ADDRESS:_____
STREET/APT #

_____
CITY STATE ZIP CODE

NAME(S) OF PARENT(S) OR GUARDIAN(S):
1. NAME_____**RELATIONSHIP:**_____**PHONE#**_____
2. NAME_____**RELATIONSHIP:**_____**PHONE#**_____

EMERGENCY CONTACT:
1. NAME_____**RELATIONSHIP:**_____**PHONE#**_____
2. NAME_____**RELATIONSHIP:**_____**PHONE#**_____
3. NAME_____**RELATIONSHIP:**_____**PHONE#**_____

PART 2: PERSONAL HISTORY---------- Please check the items below that apply to your child

- Language spoken at home: _____ Is your child fluent in English? ☐YES ☐NO
- **ETHNICITY: Hispanic Caucasian Asian Black American Indian Middle Eastern**
- Referral from Child Find or other education agency? If yes, please specify: ☐YES ☐NO
  REASON(S) FOR REFERRAL_____AGENCY_____
- **Kindergarten District** Initial_____date_____

PART 3: PRIOR CARE EXPERIENCE ---- Where did your child spend the most time in the last 12 months?

☐ Home care ☐ Head Start ☐ Pre-Kindergarten ☐ Childcare Center ☐ Family Childcare

☐ Preschool special education program ☐ Parents ☐ Other_____

_____You agree to Gym Magic's attendance policy. Your child can only have excused absences and must maintaining a 95% attendance rate

_____Permission for screenings: vision, dental, hearing, ASQ

PART 4: HEALTH INFORMATION -------- Please check the items below that apply to your child

☐Delayed speech/language ☐Hearing problems ☐Vision problems ☐ Occupational therapy

☐Parent concerns about child's development ☐Asthma ☐Attention span ☐Use of medication

Please list any other therapy child is receiving:_____

Please list health problems:_____

Please list physical limitations:_____

Please list allergies (including food)_____

Please list regular medications (prescribed and over-the-counter):

_____

Family Physician:_____ Phone :_____ Last checkup_____

Family Dentist:_____ Phone:_____ Last checkup_____

Optometrist:_____ Phone:_____ Last exam_____

Health Insurance:_____ PHONE:_____

MEDICAID:_____ PHONE:_____

PART 5: AUTHORIZATION FOR PICK-UP (ID REQUIRED)-MUST SHOW A VALID PICTURE ID

NAME_____ **RELATIONSHIP:**_____ **PHONE#**_____

NAME_____ **RELATIONSHIP:**_____ **PHONE#**_____

NAME_____ **RELATIONSHIP:**_____ **PHONE#**_____

The following people CANNOT or DO NOT have permission to pick up_____

NOT AUTHORIZED_____ **RELATIONSHIP:**_____

NOT AUTHORIZED_____ **RELATIONSHIP:**_____

TO BE CONSIDERED FOR ENROLLMENT:

1. **YOU MUST ANSWER ALL QUESTIONS ON APPLICATION FORM**
2. **ESPECIALLY IMPORTANT ARE THE HIGH LIGHTED AREAS, THE INCOME ELIGIBILITY FORM, AND PARTICIPANT ENROLLMENT FORM**

Signature of parent or guardian_____ **Date** _____

CHILD AND ADULT CARE FOOD PROGRAM

Letter to Households

Instruction: This letter must accompany the Income Eligibility Application

Dear Parent/Guardian or CACFP Participant:

Gym Magic dba Ashley's Garden Participates in the Child and Adult Care Food Program (CACFP)
Name of Center

administered by the United States 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 family day care 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.

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 to only 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 day care center then you need to only list their case number sign and date the form. Otherwise an adult household member must complete form and disclose total current household income by source, and the names of all household members. The person completing the form must sign and provide a social security number and date the form when it was completed.

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).

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.

Household Size	**REDUCED Price Meals**		
	Year	Month	Week
1	22,311	1,860	430
2	30,044	2,504	578
3	37,777	3,149	727
4	45,510	3,793	876
5	53,243	4,437	1,024
6	60,976	5,082	1,173
7	68,709	5,726	1,322
8	76,442	6,371	1,471
For each additional family member	+7,733	+645	+149

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal and, where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136.

The Children, Youth and Families Department/Family Nutrition Bureau is the State Agency administering the Child and Adult Care Food Program in New Mexico, for any program assistance or information concerning the administration of the program, write to CYFD/Family Nutrition Bureau, P.O. Drawer 5160, 1920 Fifth Street, Santa Fe, New Mexico 87502-5160 or call (505) 827-9961, 1-(800) EAT-COOL.

Thank you for your cooperation.

INCOME ELIGIBILITY APPLICATION

Free and Reduced meals in the Child and Adult Care Food Program

Gym Magic dba Ashley's Garden assures the New Mexico Children, Youth and Families Department, Early Childhood Services, (***Center Name***)
Child and Adult Care Food Program, that all enrolled participants in attendance will be offered the same meals without physical segregation of, or other discriminatory action against, any child or adult participant on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal and, where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

INSTRUCTIONS: Complete this form and return to the Centers office.

Notation: (SNAP) *Supplemental Nutrition Assistance Program (formerly the Food Stamp Program)*

***Child Care Centers**: o apply for **FREE** meals - If you are receiving benefits under Supplemental Nutrition Assistance Program (SNAP) or Food Distribution rogram on Indian Reservations (FDPIR) fill in your child's name, date of birth, age, the SNAP Case number or FDPIR case number and ign the form. DO NOT completes other Household Members or income information.

****Adult Day Care:** To apply for **FREE** meals - If enrolled participant household is recipient of Supplemental Nutrition Assistance Program (SNAP) or receives Supplemental Security Income (SSI) or Medicaid (MED), complete name, DOB, age, SNAP, SSI, and/or Medicaid case number and sign the form. DO NOT complete other Household Members or income information.

Enrolled Participant(s) Information (attach additional pages if necessary)				**Benefit Information** *(If applicable check type of benefit & provide the required case number)*	
Name: *Last:* *First:*	If foster Child Check here	Date of Birth:	Age	**Child Care Centers Only-check a box* ☐SNAP ☐FDPIR	***Adult Care Centers Only-* *check a box* ☐SNAP ☐FDPIR ☐SSI ☐MED
		/ /		*Case Number:	**Case Number:
		/ /			
		/ /			
		/ /			

Foster Child (complete if a foster child is enrolling for care)
Check this box if this application includes a foster child. List the amount of child s personal use monthly income $ if there is no income, record "0".

All Other Household Members List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to

Name: *Last:* *First:*	*Name:* *Last:* *First:*

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 (Alimony): $	Social Security: $
Pension or Retirement: $	Unemployment: $	Other Income: $
If necessary, convert multiple income schedules to annual income (Multiply weekly income by 52, biweekly by 26, monthly by 12)		

Total Income: $_____ (*Check one*) ***Weekly*** ___ ***Monthly*** ___ ***Annually*** _____

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.

_____ * * * - * * - ☐☐☐☐ If the Adult Household Member signing this form does not have a Social Security Number, Check this box. ☐ _____

Signature of Adult Family Member *Social Security Number* *Date*

Privacy Act Statement: This explains how we will use the information you give us. 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 If the 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 or 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 day care center. 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 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.

FOR SPONSOR USE ONLY

☐ **Child Day Care Center:**

_____ _____ Gym Magic dba Ashley's Garden _____

Approving Date *Date Disenrolled* *Name of Organization* *Name of Person Approving Form*

PARENT/CHILD ENROLLMENT FORM

Child and Adult Care Food Program

EARLY CARE / FAMILY NUTRITION BUREAU (505) 827-9954

Name of Provider: _____ Name of Sponsor _____ Sponsor's Telephone Number: _____

You as a Parent or Guardian are enrolling your child or children in the Child and Adult Care Food Program. The CACFP is a federally funded program under United States Department of Agriculture (USDA). The program is intended to reimburse the day care provider for nutritious meals served to enrolled children. Therefore, all food served to children should be supplied only by the day care provider if he/she is being reimbursed for that meal service. 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, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

1. CHILD IDENTIFICATION

Meal Ranges: Breakfast: 7:00 am - 9:00 am / AMS: 9:00 am - 11:00 am / Lunch: 11:00 am - 1:00 pm / PMS: 2:00 pm - 4:00 pm / Supper: 5:00 pm - 7:00 pm

CHILD'S FIRST & LAST NAME	ETHNICITY	M/F	Child's Relationship to the Provider (if any)	Child's Date of Birth	DAYCARE HOURS							ANTICIPATED MEALS					
					MON	TUE	WED	THU	FRI	SAT	SUN	BRK	AMS	LUNCH	PMS	SUPPER	LATE
					HOURS												

2. NAME OF PARENTS OR GUARDIAN

Mother's Name _____ Home Mailing Address: _____ Home Phone # _____

Place of Employment/Address _____ Work Phone # _____

Father's Name _____ Home Mailing Address: _____ Home Phone # _____

Place of Employment/Address _____ Work Phone # _____

3. RELATIVE or PERSON TO CONTACT IN CASE OF EMERGENCY (Other than the Provider)

A. Name _____ Phone # _____

Name _____ Phone # _____

B. Name of Physician _____ Address _____ Zip Code _____ Phone # _____

C. Name of Hospital / Urgent Care _____ Address _____ Zip Code _____ Phone # _____

Comments: (Insurance Information, Known Allergies etc..)

4. AUTHORIZATION

I understand that my child(ren) is/are enrolled in a family day care home. I understand that the day care provider is monitored at least 4 times a year for program compliance. I also understand that I may be contacted to verify information about my child's participation in the CACFP. I give my permission to the provider to administer medicine as prescribed by a physician or myself and to seek professional medical care in an emergency. I also agree to pay all the costs and fees associated with any emergency medical care and/or treatment for my child (children).

_____ Signature of Parent or Guardian

_____ Signature of Day Care Provider

_____ Date

NMCYFDECS/FNB Revised 07/2018

White: Sponsor, Yellow: Provider, Pink: Parent