Enrollment Application Checklist

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SAMPLE CHILDREN'S ENROLLMENT FORM

Entrance Date_____ **Withdrawal Date**_____

Child's Name_____ Sex___ Age_____ Date of birth_____

Home Address (Street)_____

City_____ State_____ Zip_____

Home Phone Number_____

Father's Name_____ Home Phone Number_____

Father's Home Address (if different from child's) Street_____

City_____ State_____ Zip_____

Father's Place of Employment _____ Work Phone _____

Employer's Street Address_____ City_____ State_____ Zip_____

Mother's Name_____ Home Phone Number_____

Mother's Home Address (if different from child's) Street_____

City_____ State_____ Zip_____

Mother's Place of Employment_____ Work Phone #_____

Employer's Street Address_____ City_____ State_____ Zip_____

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

The child may be released to the person(s) signing this agreement or to the following:

*Name_____ Address_____
(Street-City-State-Zip)
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

*Name_____ Address_____
(Street-City-State-Zip)
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name of Public or Private School child attends, if any:_____

Child's doctor or clinic name_____

Doctor/clinic phone #_____

My child has the following special needs_____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:_____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns:_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name)_____ Date of birth_____ suffer an injury or illness while in the care of (Facility name)_____ and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian:_____
Signature

Date:_____

Facility Administrator/Person-In-Charge_____
Signature

Date:_____

Parental Agreements with Child Care Facility

The _____ agrees to provide child care for
(Name of Facility)
_____ on _____ _____ a.m. to _____ p.m.
(Name of Child) (Days of Week)
from _____ to _____.
(Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast
Morning Snack
Lunch
Afternoon Snack
Evening Snack
Dinner
Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The _____ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for
_____.
(Name of Facility)

I understand that the facility will advise me of my child’s progress and issues relating to my child’s care as well as any individual practices concerning my child’s special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Person-In-Charge)

GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to_____ providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by _____ providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

SIGNATURE (Parent/Guardian): _____

DATE: _____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the _____ provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the _____ provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, _____, by photograph and/or videotape in connection with daily activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the _____ provider, DECAL, and other entities contracted by the _____ provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PROVIDER NAME/ADDRESS: KWA (914 PALM/725 WRIGHT ST. BAINBRIDGE GA 39817

PARENT GUARDIAN SIGNATURE: _____

DATE: _____

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file

DECAL SAMPLE

Safe Sleep Practices Policy

Child's name:_____ Date of birth:_____

Parent/Guardian name:_____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:

_____

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature_____ Date_____

Van Rules and Regulations

**** Van transportation in the morning is for parents who are working. Due to limited space a parent must be scheduled to work by 7:30 am. If you are off you will be required to take your child to school in the morning. All children must be here at 6:45 am to catch van; we pull out at 6:55 am.

****Children under 8 years of age must have a high back booster seat to ride the van in the morning and the afternoon (we do not provide seats). If your child only rides in the afternoon it will be your responsibility to drop off the seat at center for us to pick them up from school.

****If your child leaves school early please contact center at 229-246-4098 to let us know so we won't be waiting for them and get behind schedule on picking up children.

****During normal school hour or while school is in session, if your child can't go to school they will not be able to attend the center for the day. NO EXCEPTIONS!!

****All children must be picked up at the designated location by 5:45 pm. Transfer from the skate town location is only for parents who work after 6:00 pm;a schedule from work will be required in order for them to be transferred to Palm Street for night shift.

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if _____
Name of Facility

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

Sample
Transportation Agreement

This is to certify that I give _____
Name of Facility

Permission to transport my child _____
Name of Child

from _____ at _____ (am/pm)
Pickup Location

to _____ at _____(am/pm).
Delivery Location

My child will be transported from _____at _____(am/pm)

to _____ at _____(am/pm)
Delivery Location

on the following days:

_____ Monday
_____ Tuesday
_____ Wednesday
_____ Thursday
_____ Friday

_____ is authorized to receive my child. In the event the authorized
Name of Authorized Person

person is not present to receive my child, the following procedures are to be followed:

_____

_____

_____

The _____is approximately _____ miles from the center.
Location
In the event that my child is not to be transported as outlined above, I agree to notify the

_____.
Facility

Signature (Parent/Guardian) _____ Date _____

INFANT FEEDING PLAN

Child's full name_____ Date_____

Date of birth_____

Does child take bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (Check all that apply)
Strained foods [ ] Whole milk [ ]
Baby foods [ ] Table foods [ ]
Formula [ ] Other [ ]
Breast Milk [ ]

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____

Does the child take a pacifier? Yes [ ] No [ ] If yes, when?_____

_____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula)_____

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods_____

_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

_____

PARENTS' SIGNATURE: _____ **Date:** _____

QUALITY CARE for CHILDREN

As a requirement of the **Child and Adult Care Food Program** (CACFP), this child care center is required to give **each household all of the documents in this packet every year regardless of your income**. This center is reimbursed by serving nutritious meals and snacks to all children enrolled for child care or afterschool care.

Parents/guardians should return all items with an asterisk (*) to your child care center main office.

A. Parent Letter with Frequently Asked Questions

B. CACFP Meal Benefit Income Eligibility Statement*

C. Sharing Information With Medicaid/SCHIP* (optional to return)

D. Infant Affidavit* (required for all infants)

E. WIC

F. Building for the Future

G. Special Accommodations for Children with Dietary Needs

For children with special eating accommodations, the **Medical Statement to Request Special Meals and/or Accommodations** form must be completed by a physician or authorized medical authority. A parent note is not adequate documentation. Ask the center for a copy or download it: www.qualitycareforchildren.org/forms.

A

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. _____ _____ offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached **Meal Benefit Income Eligibility Statement** form. In addition, by filling out this form, we will be able to determine the rate for reimbursement our center will receive for feeding your child. **This form will be filed and treated as confidential information.**

Quality Care for Children (QCC) is an administrative sponsor for CACFP and works with this child care center and/or afterschool program. QCC will help ensure our program operates and complies with USDA standards. For more information about QCC, go to www.qualitycareforchildren.org.

Frequently Asked Questions

1. Do I need to fill out a Meal Benefit Form for each of my children in day care?
You may complete one form for all children enrolled in child care in your household only that are enrolled at the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully. **Return the completed form to the main office of the child care center. The center director will return the completed form to QCC for processing.**

2. Who can get free meals without providing income information?

- Children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals.
- Foster children
- Children enrolled in Head Start or Early Head Start
- Runaways
- Children of migrant agricultural workers
- Homeless children

3. Who can get reduced-price meals?
Your children can get low cost meals if your household income is within the reduced-price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen?
Yes. Neither you nor your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Whom should I include as members of my household?
You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status?
The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-priced benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same?
List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

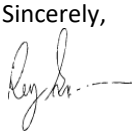
8. We are in the military. Do we include our housing and supplemental allowances as income?
If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

Definitions for Part 1 of the CACFP Meal Benefit Income Eligibility Statement

Foster Children	**Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals.** Foster care means 24-hour substitute care for children placed away from their parents or guardians and for whom the state agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child-care institutions, and pre-adoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the state or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is federal matching of any payments that are made.
Head Start **Early Head Start** *Proof required	Children enrolled in federal and state-funded Head Start or Early Head Start Programs are categorically eligible to receive free meal benefits without further application or eligibility determination as long as the child is enrolled in Head Start or Early Head Start at the time the annual eligibility determination is made. **Forms of acceptable documentation that must be included with your form to prove Head Start status:** **1. approved Head Start application,** **2. statement of Head Start enrollment, or** 3. **list of participants from a Head Start official**
Migrant Child	Migrant family means, for CACFP eligibility, a family with children under the age of compulsory school attendance who changed their residence by moving from one geographic location to another, either intrastate or interstate, **within the preceding two years to engage in agricultural work and whose family income comes primarily from this activity**.
Runaway Youth	This means an individual who is less than 18 years of age and who absents himself or herself from home or a place of legal residence without the permission of a parent or legal guardian.
Homeless	Children and youth who lack a fixed, regular, and adequate nighttime residence.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability. If you have questions or comments, contact QCC at 404-479-4195. Monday through Friday. 8:30 am – 5:00 pm.

Sincerely,



Reynaldo Green, Vice President, Health and Nutrition – Child Care Food Program

These are the income scales used by the United States Department of Agriculture to determine eligibility for reimbursement in the Child and Adult Care Food Program. Incomes at or below this scale are eligible for reimbursement from July 1, 2018 to June 30, 2019.

INCOME ELIGIBILITY GUIDELINES

	Reduced Price Meals – 185%			Free Meals – 130%		
Household Size	Annual Income	Monthly Income	Weekly Income	Annual Income	Monthly Income	Weekly Income
1	22,459	1,872	432	15,782	1,316	304
2	30,451	2,538	586	21,398	1,784	412
3	38,443	3,204	740	27,014	2,252	520
4	46,435	3,870	893	32,630	2,720	628
5	54,427	4,536	1,047	38,246	3,188	736
6	62,419	5,202	1,201	43,862	3,656	844
7	70,411	5,868	1,355	49,478	4,124	952
8	78,403	6,534	1,508	55,094	4,592	1,060
For each additional family member, add:	+7,992	+666	+154	+5,616	+468	+108

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 your child for free or reduced price meals. You must include the social security 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 Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Name of Child Care Center: _____

CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	Date of Birth (Optional) MM/DD/YY	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	**Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)**				
			Head Start	Foster Child	Migrant	Runaway	Homeless
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

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

A. Child Income - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here.

All children income/How often?
$_____/_____

B. Other Household Members. List all household members (including yourself) not listed in Part I even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. **If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often	2. Welfare, child support, alimony / How Often	3. Social Security, pensions, retirement / How Often	4. All other income / How Often
(Example) Jane Smith	$___200/week____	$_150/twice a month	$___100/month_ __	$_____/_____
1. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
2. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
3. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
4. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
5. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

D. Social Security Number. If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.** Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: **Sunday Monday Tuesday Wednesday Thursday Friday Saturday**

Circle the meals your child will normally receive while in care: **Breakfast AM Snack Lunch PM Snack Supper Evening Snack**

PART IV: Signature

*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. **If not completed fully and signed, the participant will be placed in the Paid category**.*

Signature: X _____ **Print Name:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ Indian or Alaska Native ☐ Hawaiian or other Pacific Islander

Official Use Only Section for QCC Staff: **Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12**

(A) Total income: _____ per ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Year

(B) Household Size: _____ **(C) Categorical Eligibility**: ☐ (Check if applicable) **(D) Eligibility**: ☐ Free ☐ Reduced ☐ Paid-Denied

(E) Day Care Homes Only: Check one ☐ Tier I ☐ Tier II **(F) Time Period:** _____

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date**: _____ **Confirming Official's Signature** _____ **Date**: _____

Follow Up Official's Signature: _____ **Date**: _____

Instructions

Households that receive SNAP, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a SNAP, TANF, or FDPIR case number. For adult day care, list participant's name and a SNAP, TANF, FDPIR, SSI or Medicaid case number. **Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children. Note:** Children in Foster care, enrolled in Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Please refer to the Q&A section for a definition of each free categorical eligibility.

Part II: Skip this part.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: Sign the form. A Social Security Number is not necessary.

Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home, child care center or adult day care, list participant's name.

Part II: To report total household income from last month, complete the following:

A- Child Income: Please indicate the TOTAL income received by **Child** household members listed in PART I. Please list any child income and how often it is received in this section.

B – **Adult Income:** List the first and last name of each **Adult** person living in your household as an economic unit. You must indicate yourself and all other adult members living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant should be listed here as well. Attach another sheet if necessary.

List Gross Income. Next to each person's name, list each type of income received last month, and how often it was received.

B-Column 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

B-Column 2: List the amount each person got last month from welfare, child support, alimony.

B-Column 3: List Social Security, pensions, and retirement.

B-Column 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Social Security Number: If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or mark the "I don't have a Social Security Number" box.

If no income: If the person does not receive income from any source, write "0". If "0" is entered or any income field are blank, the person is certifying that there is no income to report. **C – Total Household Members. Please list the total number of all household members (children and adults) in this section.**

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: An adult household member must complete this section completely and then sign the form. Please refer back to Part II to ensure the last four digits of his/her social security number have been recorded or the box has been marked if he/she does not have one.

Part V: Answer this question if you choose to.

Privacy Act Statement: This explains how we use the information you give us.

C Sharing Information with MEDICAID/SCHIP

Name of Child Care Center: _____

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to***. Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to **the child care center office. It will be forwarded to Quality Care for Children, Nutrition Department, 2751 Buford Highway NE, Suite 500, Atlanta, GA 30324** right away. (Sending in this form will not change whether your children get free or reduced price meals.).

❑ **No! I DO NOT** want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

_____

For more information, you may call **Quality Care for Children** at 404-479-4255 or 404-479-4253. If you wish to apply for these benefits through Medicaid or SCHIP, contact your local county DFCS office.

D

Infant Affidavit

MANDATORY FOR ALL INFANTS IN CARE

In CACFP, programs must offer a USDA approved "ready-to-feed" commercially prepared iron-fortified milk-based infant formula to infants in their care. The Georgia Department of Early Care and Learning only permits these types of commercially prepared, "ready-to-feed" formula.

To be completed by center BEFORE giving to parents:

Name of Sponsor: Quality Care for Children

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program, I must offer to provide meals to all infants enrolled for care in my center/facility.

I, _____ (name of center), will provide the following to infants enrolled for care in my facility:

- _____ (name of milk-based iron-fortified formula) and
- _____ (name of iron-fortified infant cereal)

Parents/Guardians:
Do not complete unless the center section above has been filled-in with both formula and cereal above.

Name of Infant: _____

Please check one of the following options and sign this form:

☐ I would like the provider/center to provide the milk-based iron fortified infant formula and iron-fortified infant cereal listed above to my infant and I will provide clean, sanitized and labeled bottles daily.

☐ I will provide the following for my infant on a daily basis:

- _____ (name of milk-based iron-fortified formula) and
- _____ (name of iron-fortified infant cereal)

_____ _____
Parent/Guardian Signature Date

*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian although the center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

E

WIC

A Special Food and Nutrition Education Program for Women, Infants and Children

Who is Eligible?

- A pregnant woman
- Breastfeeding woman
- A woman who recently been pregnant
- An infant or a child less than 5 years old

Services Provided:

- Nutritious foods
- Nutrition counseling
- Healthcare referral

To be eligible, you must also:

- Have a low or moderate income AND
- Have a special need that can be helped by WIC foods and nutrition counseling

Approved WIC Foods:

Milk, cheese, cereals, peanut butter, fruit or vegetables juices, dry beans or peas, iron fortified formula

You do not have to be on public assistance to apply.

Call your local health department for more information.

Georgia WIC Program

State WIC Office
Division of Public Health
Georgia Department of Human Services
Two Peachtree Street, NW
10th floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
http://wic.ga.gov

(Effective from July 1, 2018 to June 30, 2019)

	Reduced Price Meals – 185%				
Household Size	**Annual Income**	**Monthly Income**	**Two per Month**	**Every Two Weeks**	**Weekly Income**
1	22,459	1,872	936	864	432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
For each additional family member, add:	+7,992	+666	+333	+308	+154

F Building for the Future

Meals

This day care facility participates in the child and Adult Care Food Program (CACFP), a federal program that provides healthy meals and snacks to enrolled participants receiving care.

Providers receive monetary reimbursement for serving nutritious meals that meet the USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snack (Two of the four groups)
Milk	Milk	Milk
Fruit or vegetables	Meat or meat alternate	Meat or meat alternate
Grains or bread	Grains or Bread	Fruit or vegetables
	Two different servings of fruits or vegetables	Grains or bread

Participating Facilities

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and for-profit centers
- **Adult Care Centers:** Public or private nonprofit and for-profits centers
- **Family Day Care Programs:** Licensed or approved private child care homes
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth
- **Emergency/Homeless Shelters:** Shelters that provide residential and food services to homeless children. Shelters are the only residential programs that may participate.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following:

- Children age 12 and under;
- Migrant children age 15 and younger
- Youths through age 18 in afterschool care programs in needy areas;
- Chronically impaired disabled adult 18 years of age or older; or
- Persons 60 years of age or older in a group setting outside their home

Contact Information

This center participates on the CACFP under the sponsoring organization listed below.
The CACFP is administered in every state and in Georgia by the agency listed below. Contact one of the following for questions about the CACFP.

Sponsoring Organization: **Quality Care for Children** 2751 Buford Highway NE, Suite 500 Atlanta, GA 30324 404-479-4251 www.qualitycareforchildren.org	**Bright from the Start: Georgia Department of Early Care and Learning Nutrition Services** 2 Martin Luther King Jr. Drive, SE Atlanta, GA 30334 404-656-5987 www.decal.ga.gov

This institution is an equal opportunity provider.