All Star Kids Academy
4518, Covington Hwy
Decatur, GA 30035-1201
Tel:(404)-284-2327
Email: info@allstarkidsacademyga.com

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: _____

Director of Facility/Administrator _____

Signature _____ Date: _____

Parental Agreements with Child Care Facility

All Star Kids Academy agrees to provide child care for _____
(Name of Child)
on Monday through Friday between 6:00 am a.m. to 6:30 p.m
from _____ to _____.
(Month) (Month)
My child will participate in the following meal plan (circle applicable meals and snacks):

- Breakfast (served from 7am to 8am)
- Lunch (served from 11am to 12.30pm)
- Evening Snack (served from 3pm to 3.30pm)
- Dinner

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.

Tuition is due every Monday, *whether or not your child is present*. It is permissible to pay two weeks in advance**. A $20 late fee may be charges for payments made after Mondays.**

After one year of enrollment you are entitled to one free vacation week. After two years you may have one and a half weeks.

Because we participate in the federal food program, we cannot allow outside food to be brought in. An exception is made for prearranged birthday parties or other celebrations.

Please note that All Star Kids Academy does not carry liability insurance.

All Star Kids Academy 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.

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(Month) (Month)

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Please note that All Star Kids Academy is not responsible for any lost or damaged items. Please keep expensive and valuable items away from the center.

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 set forth in the Parent's Handbook for All Star Kids Academy.

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: _____
Director of Facility/ Administrator

ALL STAR KIDS ACADEMY
Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Child's Address _____

City: _____ GA _____ (zip)

Parent/Guardian Name _____ relationship _____

Home Phone _____ Work Phone _____ Work Place: _____

Work Address: _____, GA

Parent/Emergency Contact _____ relationship: _____

Home Phone _____ Work Phone _____ Work Place: _____

Work address: _____, GA

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

Name _____ Phone _____

Child's Doctor _____ Phone _____

Doctor's address: _____, GA

Medical facility the center uses **Egleston Children's Hospital**
Address: 1405 Clifton Rd.; Atlanta, GA 30322 Phone: 404-325-6000

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if All Star Kids Academy, Inc. 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.

Signature (Parent/Guardian) _____

Witness By _____ Date _____

Date: _____

Dear Parent;

Our Mission here at All Star Kids Academy is to provide quality childcare, at all times, five days a week. We also want to assure you that we do our very best to make sure that your children are well taken care of and treated with loving kindness. We provide an important nurturing environment for them. We also provide a great learning experience through curriculum along with other learning and playing experiences. That is the reason that the following information is so important.

You presently have a DFCS/CAPS or Maximus certificate for subsidized tuition. This is an agreement/contract between you and Department of Family & Children Services (DFCS). All Star Kids Academy (ASKA) has an agreement with DFCS that they will invoice ASKA for the amount of the subsidy they have agreed upon with you. It is your responsibility to keep up with DFCS as far as having and keeping a valid certificate. If for any reason DFCS stops invoicing ASKA for the subsidy amount or if the amount decreases, you are responsible to pay ASKA whatever DFCS does not.

ASKA is in no way involved in any Agreement or Contract whatsoever between you and DFCS. Any agreements as to eligibility, qualifications, and subsidies they pay, etc, etc. is strictly between you and DFCS.

Enrollment in ASKA, the care of your children, your portion of the tuition and other costs, any matters which concern your children, is an agreement between you and All Star Kids Academy, Inc. Below is a list of our policies and agreements with you, most of which is covered in ASKA's Policy and Procedure booklet.

1. **You must pay the full tuition for your children until you have a valid certificate.**
2. **You have received and read ASKA's Policy and Procedure Manuel. You understand and agree to these policies.**
3. **You agree to pay the difference between the actual amount that DFCS pays and ASKA's total tuition costs. This includes any fees not paid by DFCS.**

As long as your child/children are enrolled in ASKA, the tuition is due EVERY WEEK on Mondays. ***If your child/children are out sick or for any other reason, the tuition is still due***. If they are out for the full week, then you are responsible to pay $65.00 as DFCS does not pay if your child does not attend. (Your child's place in the classroom is comparable to your home, You pay a monthly payment whether or not you are there. Tuition is actually a yearly fee, broken into weekly payments for your convenience.)

4. **If you decide to withdraw your children from ASKA for any reason, you must give two (2) full weeks notice. If no notice is received, you will be charged for those two weeks.**
5. **There will be extra charges for additional services such as for children in the before and after school program, when school is out and they are here for the full day. Posters and signs will be posted announcing these events in advance.**
6. **All changes of jobs, schools, your schedule, times your children will attend ASKA, phone numbers, both work and home, along with address changes *MUST* be reported to the office *immediately* for your child's sake. For your protection, these changes also need to be turned in to DFCS in writing (be sure and get a date stamped confirmation from them.)**

We welcome you and your children here at All Star Kids Academy, Inc where we believe all KIDS ARE STARS!

Please sign below that you understand the terms of your children's enrollment at All Star Kids Academy, Inc. This agreement is due back with your completed enrollment package.

I have read and understand the terms of care for my children at All Star Kids Academy, Inc.

_____ _____ _____

Parent/Guardian Name Date Signature

Weekly Fee: _____

Children's Names: _____

_____

All Star Kids Academy
(re: Meals)

Dear Parent or Guardian,

All Star Kids Academy (ASKA) participates in the USDA Child and Adult Care Food Program (CACFP), which is administered on a state level by Bright from the Start: Georgia Department of Early Care and Learning. Please assist us in our participation of this program by completing and returning the enclosed statement as soon as possible. This is necessary so that ASKA can receive reimbursement for meals served to your children. This form is kept confidential.

Instructions for completing this form can be found on the statement. If your household size/income is at or below the income limits on the attached document, the participants' meals are eligible for free or reduced price reimbursement. In order for the center to receive reimbursement for meals, the documentation in either part 2A or 2B is needed:

2A) Food Stamp/TANF/Foster Families/ Food Distribution on Indian Reservations Households: If your household currently receives SNAP, TANF, or FDPIR benefits or if the enrolled child is a foster child, your child is automatically eligible for free reimbursement. Please list your child's name and SNAP Client ID number, then skip to the signature section of the Income Eligibility Form. The EBT card number is not an acceptable number.

2B) List the names of the parents/guardians, all children and other residents of the household along with any income and the frequency of income (i.e., weekly, biweekly, twice a month, etc.)

The last 4 digits of your social security number must be entered in part C.

Part III: Please circle the days your child will be present, and hours they will attend.

Part IV: Please sign and enter your address and phone number.

Staff from Bright from the Start may contact you to verify the information provided. This contact may occur by phone or by mail. Household notifications are required by federal regulations under various situations.

In the operation of USDA food service programs, no one will be discriminated against because of race, national origin, sex, age, or disability. If you believe that you have been discriminated against, write immediately to : USDA, Director, Office of Civil Rights, 1400 Independence Ave SW Washington DC, 20250-9410 or call (800)795-3272 or (202) 720-6382.

Sincerely,

Jackie Boldt

All Star Kids Academy

Note: Attached Income Eligibility Statement

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.

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.

Bright from the Start: Georgia Department of Early Care and Learning

CACFP Meal Benefit Income Eligibility Statement*

hild(ren) or Adult enrolled to receive day care

ame: (Last, First and Middle Initial)	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[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? $_____/_____

B. Other Household Members[1]. List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. 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?
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____

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

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:** _____

***This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.**

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 Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size:** _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility**: check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

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:** _____

...NG INFORMATION WITH MEDICAID/SCHIP

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 [address] by [date]. (Sending in this form will not change whether your children get free or reduced-priced 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 _____ at _____
CACFP Meal Benefit Income Eligibility Form Sharing Information with Medicaid/SCHIP.

WIC

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

WHO IS ELIGIBLE?

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

SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care 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, eggs, cereals, peanut butter, fruit or vegetable 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

Georgia WIC
Georgia Department of Public Health
2 Peachtree Street, NW
10th Floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
Website: http://dph.georgia.gov/WIC

INCOME ELIGIBILITY GUIDELINES
(Effective from July 1, 2022 to June 30, 2023)

Household Size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	25,142	2,096	1,048	967	484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
For each additional family member add	+ 8,732	+728	+ 364	+336	+ 168