

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operator's Name		Director's Name		Spirits' Heart Childcare Center	
Child's Full Name		Child's Date of Birth		Child Lives With	
<input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian		Date of Admission		Date of Withdrawal	
Name of Parent or Guardian Completing Form			Address of Parent or Guardian (if different from the child's)		
List telephone numbers below where parents/guardian may be reached while child is in care.					
Parent 1 Telephone No.		Parent 2 Telephone No.		Guardian's Telephone No.	
<input type="radio"/> Yes <input type="radio"/> No		Custody Documents on File		Relationship	
Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached.					
I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.					
Name		Phone Number		Name	
Name		Phone Number		Name	
Name		Phone Number		Name	

Consent Information

Check All That Apply:

1. Transportation
 I give consent for my child to be transported and supervised by the operation's employees:
 for emergency care
 on field trips
 to and from home
 to and from school

2. Field Trips
 I give consent for my child to participate in field trips.
 I do not give consent for my child to participate in field trips.
 Comments

3. Water Activities

I give consent for my child to participate in the following water activities:

- water table play
- sprinkler play
- splashing/wading pools
- swimming pools
- aquatic playgrounds

4. Receipt of Written Operational Policies (Check All that Apply)

I acknowledge receipt of the facility's operational policies, including those for:

- Discipline and guidance
- Suspension and expulsion
- Emergency plans
- Procedures for conducting health checks
- Safe sleep
- Procedures for parents to discuss concerns with the director
- Procedures for parents to participate in operation activities
- Procedures for release of children
- Illness and exclusion criteria
- Procedures for dispensing medications
- Immunization requirements for children
- Meals and food service practices
- Procedures to visit the center without securing prior approval
- Procedures for parents to contact Child Care Licensing (CCL), DFS, Child Abuse Hotline, and CCL website

5. Meals

I understand that the following meals will be served to my child while in care:

- None
- Breakfast
- Morning snack
- Lunch
- Afternoon snack
- Supper
- Evening snack

6. Days and Times in Care

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Authorization For Emergency Medical Attention

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone Number
Name of Emergency Care Facility	Address	Phone Number

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian

Child's Additional Information Section

any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? Yes No Plan Submitted on _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian _____
Date Signed _____

School Age Children

My child attends the following school _____
School Phone Number _____

child has permission to (check all that apply):

- walk to or from school or home
- ride a bus
- be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address

Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Check **only one** option:

- Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Signature — Health Care Professional _____
Date Signed _____

- A signed and dated copy of a health care professional's statement is attached.
- Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name _____
Address of Health Care Professional _____

Signature — Parent or Legal Guardian _____
Date Signed _____

Requirements for Exclusion

I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/		Left Eye 20/		<input type="radio"/> Pass	<input type="radio"/> Fail
Signature		Date Signed			

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1-2 months (second dose)	
	6-18 months (third dose)	
	2 months (first dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15-18 months (fourth dose)	
Diphtheria, Tetanus, Pertussis	4-6 years (fifth dose)	
	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12-15 months (fourth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	

Positive Negative Date: _____

TB Test (if Required)

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

Additional Information Regarding Immunizations

Signature _____

Date Signed _____

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

Varicella (Chickenpox)

Signature _____

Date Signed _____

Signature or stamp of a physician or public health personnel verifying immunization information above:

Physician or Public Health Personnel Verification

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Inactivated Poliovirus	12-15 months (fourth dose)	
	2 months (first dose)	
	4 months (second dose)	
	6-18 months (third dose)	
Measles, Mumps, Rubella	12-15 months (first dose)	
	4-6 years (second dose)	
	12-15 months (first dose)	
	4-6 years (second dose)	
Varicella	12-15 months (first dose)	
	4-6 years (second dose)	
Hepatitis A	12-23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>

Signatures

Center Designee	Date Signed
Child's Parent or Legal Guardian	Date Signed

CACFP STUDENT ENROLLMENT FORM

Spirit's Heart Childcare Center participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to annually review and make changes to enrollment data.

	CHILD(REN) INFORMATION	
<p style="text-align: center;">SITE / SPONSOR USE ONLY</p> <p>Withdrawal Date: ____/____/____ Re-Enroll Date: ____/____/____</p>	<p style="text-align: center;">Center Enroll Date</p> <p>Child's First Name Child's Last Name Child's Birth Date</p> <p style="text-align: center;">Normal Days in Care</p> <p style="text-align: center;">Center's Days of Operation: M-F</p> <p style="text-align: center;">Normal Hours in Care</p> <p style="text-align: center;">Center's Hours of Operation: 08:30 AM-05:00 PM</p> <p style="text-align: center;">Meals/Snacks Child Receives</p> <p style="text-align: center;">Meals/Snacks Served at Center: BRK, LUN, PMS, SUP</p>	<p style="text-align: center;">Ethnic Identity (Check one)</p> <p><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <p style="text-align: center;">Racial Identity (Check all that apply)</p> <p><input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan <input type="checkbox"/> Native Hawaiian / Other <input type="checkbox"/> Pacific Islander</p> <p style="text-align: center;">Gender Identity (Check one)</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p>
<p style="text-align: center;">SITE / SPONSOR USE ONLY</p> <p>Withdrawal Date: ____/____/____ Re-Enroll Date: ____/____/____</p>	<p style="text-align: center;">Center Enroll Date</p> <p>Child's First Name Child's Last Name Child's Birth Date</p> <p style="text-align: center;">Normal Days in Care</p> <p style="text-align: center;">Center's Days of Operation: M-F</p> <p style="text-align: center;">Normal Hours in Care</p> <p style="text-align: center;">Center's Hours of Operation: 08:30 AM-05:00 PM</p> <p style="text-align: center;">Meals/Snacks Child Receives</p> <p style="text-align: center;">Meals/Snacks Served at Center: BRK, LUN, PMS, SUP</p>	<p style="text-align: center;">Ethnic Identity (Check one)</p> <p><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <p style="text-align: center;">Racial Identity (Check all that apply)</p> <p><input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan <input type="checkbox"/> Native Hawaiian / Other <input type="checkbox"/> Pacific Islander</p> <p style="text-align: center;">Gender Identity (Check one)</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p>
<p style="text-align: center;">SITE / SPONSOR USE ONLY</p> <p>Withdrawal Date: ____/____/____ Re-Enroll Date: ____/____/____</p>	<p style="text-align: center;">Center Enroll Date</p> <p>Child's First Name Child's Last Name Child's Birth Date</p> <p style="text-align: center;">Normal Days in Care</p> <p style="text-align: center;">Center's Days of Operation: M-F</p> <p style="text-align: center;">Normal Hours in Care</p> <p style="text-align: center;">Center's Hours of Operation: 08:30 AM-05:00 PM</p> <p style="text-align: center;">Meals/Snacks Child Receives</p> <p style="text-align: center;">Meals/Snacks Served at Center: BRK, LUN, PMS, SUP</p>	<p style="text-align: center;">Ethnic Identity (Check one)</p> <p><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <p style="text-align: center;">Racial Identity (Check all that apply)</p> <p><input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan <input type="checkbox"/> Native Hawaiian / Other <input type="checkbox"/> Pacific Islander</p> <p style="text-align: center;">Gender Identity (Check one)</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p>

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature _____
Date _____

Parents' First Name _____
Parents' Last Name _____

Cell Phone _____

Non-Discrimination Statement: 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: <https://www.usda.gov/easrc/how-to-file-a-program-discrimination-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: (1) mail: U.S. Department of Agriculture (2) fax: (202) 690-7442, or (3) email: usda-complaint@aphis.usda.gov.

**Income Eligibility Guidelines
Determining Free and Reduced-Price Benefits**

July 01, 2021 - June 30, 2022

ingresos máximos para determinar la elegibilidad para el programa de nutrición 01 julio, 2021 - 30 junio, 2022

FAMILY SIZE	ANNUAL REDUCED	MONTHLY REDUCED	TWICE PER MONTH REDUCED	EVERY TWO WEEKS REDUCED	WEEKLY REDUCED
1	\$23,828	\$1,986	\$993	\$917	\$459
2	\$32,227	\$2,686	\$1,343	\$1,240	\$620
3	\$40,626	\$3,386	\$1,693	\$1,563	\$782
4	\$49,025	\$4,086	\$2,043	\$1,886	\$943
5	\$57,424	\$4,786	\$2,393	\$2,209	\$1,105
6	\$65,823	\$5,486	\$2,743	\$2,532	\$1,266
7	\$74,222	\$6,186	\$3,093	\$2,855	\$1,428
8	\$82,621	\$6,886	\$3,443	\$3,178	\$1,589
For each additional family member add:	\$8,399	\$700	\$350	\$324	\$162

Children from households whose incomes are at or below the levels shown above, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced - price meals."

Adult Day Care participants whose household incomes are at or below the levels shown above, or who receive medical, Supplemental Security Income (SSI) or SNAP benefits, are eligible for free or reduced-price meals.

Los niños de hogares con ingresos iguales o menores a los niveles indicados anteriormente, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o Reservas Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles indicados anteriormente, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Spirit's Heart Childcare 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 Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to the child care center's director.**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program or the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

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 Income Chart, sent with 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. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who 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, I 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 estimate 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 price benefits, whether through income or by providing a current SNAP, TANF, FDIR 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 normally get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on their Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

9. 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.

10(Pricing program only) Will the information I give be verified? Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You can talk to Army Pringle, either in person or by telephone at (832) 282-1351. You may ask for a hearing by calling or writing to Max Taylor, Advance Child Care, Inc.; 523 West First Ave; Corsicana, Texas 75110, (903) 872-5231.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

You have other questions or need help, call Army Pringle at (832) 282-1351.

Sincerely,

Angela Childress

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)



Center Name

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)

CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.

CHECK IF NO INCOME

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDFPIR, provide the name and eligibility number for the person who receives benefits. If no one receives these benefits, skip to part 3.

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed List of Eligible Federal/State Funded Programs (H1660), provide the name of the program and eligibility number: NAME: ELIGIBILITY NUMBER:

Check here if no eligibility number

Part 4. Total Household Gross Income—You must tell us how much and how often

B. Gross income and how often it was received

Note: Self-employed report income after expenses in box 1

A. Name (List only household members with before deductions 1. Earnings from work 2. Welfare, child support, alimony 3. Pensions, retirement, Social Security, SSI, VA benefits \$200/weekly \$150/twice a month \$100/monthly \$200/bi-monthly

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the next page.)

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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: Print name:

Date:

Address:

Phone Number:

State:

Zip Code:

City:

Last four digits of Social Security Number: * * * * - * * * * I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)



Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: Not Hispanic or Latino Hispanic or Latino

Mark one or more racial identities: Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Black or African American

Part 7. Sharing Information with Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- I do elect to allow my household information to be disclosed.
- I do not elect to allow my household information to be disclosed.

Don't fill out this part. This is for official use only.

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 Month Year Household size: _____

Categorical Eligibility: Date Withdrawn: _____ Eligibility: Free Reduced Denied Tier I Tier II

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement:

Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but 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 you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

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 <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-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:

- (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.

Box 1: List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDIPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDIPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

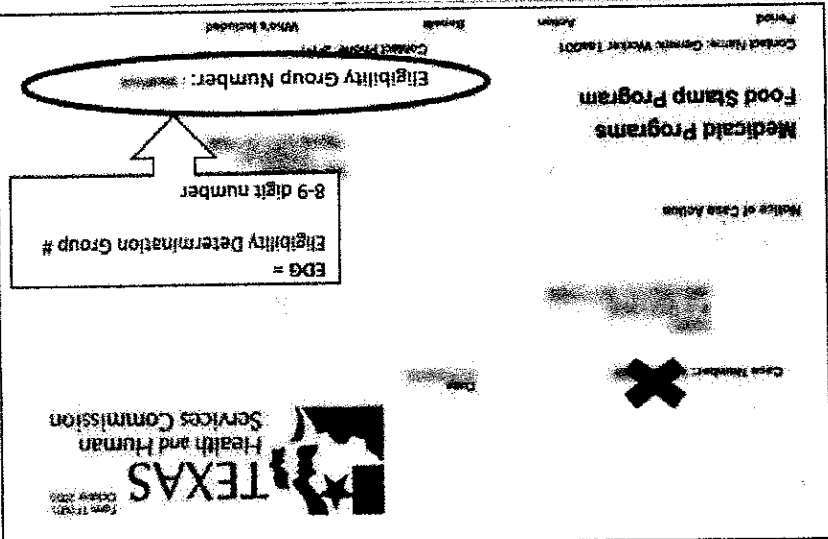
Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

INSTRUCTIONS FOR CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDIIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDIIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC (see illustration).



Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

if you are applying on behalf of a FOSTER CHILD, follow these instructions:
 If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. A Social Security Number is **not** necessary.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

if some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have an eligibility number, skip this part.

Part 3: Applies only to parents/guardians of children in Tier II Day Care Homes. Sponsors must provide the *List of Eligible Federal/State Funded Programs (H1660)*, with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. See next.

MINOR (CHILD) PHOTO RELEASE FORM

I, _____, the parent or legal guardian of _____ [Child] grant Spirit's Heart Childcare Center

[Party Receiving Permission] my permission to use the photographs described as all inside/outside the daycare premise [Describe Photographs] for any legal use, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

Furthermore, I understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Parent/Guardian's Signature: _____ Date _____

Parent/Guardian's Name: _____

Child's Name: _____

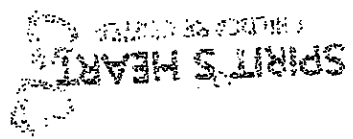
Phone Number: _____



_____ Date:

_____ Signature:

_____ give my child/children,
_____ Permission to learn American Sign
language (ASL). Via classroom, San Antonio College
Interns, Educational Videos, TTY Equipment from Texas
School of the Deaf, and Volunteer Interpreters.



Information on Health Checks

Purpose: This is an optional form designed to give you information on how to develop operational policies for health checks if your operation conducts health checks.

What is a health check?
A health check is defined as a visual or physical assessment of a child to identify potential concerns about a child's health, including signs or symptoms of illness and injury, in response to changes in the child's behavior since the last date of attendance.

What does the operational policy need to include?
The written operational policy must outline your program's procedures for health checks.

My program does not have procedures for health checks, how do I create these?
While the minimum standards do not specify what the procedures must include, suggested procedures include:

- When a health check is conducted
- Who conducts the health check
- How the health check is conducted
- What must be documented (if applicable)
- What happens if a child is ill or injured (is appropriate to cross reference current operational policies on illness and exclusion as well as handling medical emergencies)
- How staff will be trained to conduct health checks

Recommendations for health checks

Observation of the child and communication with the child's parent or guardian are the key elements of a health check.

Greet the child and do the following:

- Look for:
 - Breathing difficulties
 - Severe coughing
 - Discharge from the nose or eyes
 - Changes in skin color
 - Bruising or swelling
 - Cuts, sores or rashes
- Give the child a hug or gently feel the child's cheek, forehead or neck (checking to see if child feels unusually warm or cold and clammy)
- If the child can talk then ask questions

Talk with the parent/guardian to find about changes in the child's:

- Sleep
- Eating and drinking
- Toileting habits
- Mood and behavior at home

Sign & Date X

Where can I find more information about health checks?
Additional information is available from Caring for our children: National health and safety performance standards; Guidelines for early care and education programs online at <http://www.cfoc.nrckids.org/>.

- Documentation
- The health check should be documented upon completion and any changes in the child's behavior or appearance should be noted.
 - There are many different ways to document health checks including the child's daily sheet, the classroom attendance record, a health check training log, or in a spiral notebook that the caregiver keeps in the room.

Information on Health Checks

Texas Dept of Family and Protective Services

Child Assessment Form

Child Name (last, first, middle)		Social Security No.*		Enrollment Date		Date of Birth	
Street Address (if rural, attach directions)		City	County	Zip			
Mailing Address (if different - street or P.O. Box)		City	County	Zip			
Telephone No. (include A/C)							

* If applicable.

1. Health

Does your child have any allergies? Yes No

If so, what allergies does your child have? _____

How should we respond if he/she has an allergic reaction? _____

Does your child have an existing illness? Yes No

Has your child had a previous serious illness or injury, or hospitalization during the past 12 months? Yes No

Is your child taking any medication? Yes No

If so, how is the medication administered, and will it need to be administered while he/she is in care? _____

Is the medication prescribed for continuous use? Yes No

Are there any side effects we should be alerted to? _____

2. Toileting:

Does your child need assistance with toileting? Yes No

How can we best help? _____

What are your ideas about toilet training? _____

How can we best help? _____

3. Behavior:

Does your child have any special fears? Yes No

How does your child communicate his/her needs? _____

Are there any special words that your child uses that might not be readily recognized? _____

How do you tell your child to stop a behavior that you don't approve of or that might be dangerous? _____

When your child gets upset, what helps him/her calm down? _____

What is a good way to distract your child when he/she is having a temper tantrum? _____

Are there any particular routines that are particularly helpful at naptime? _____

Child Assessment Form

What position is most comfortable for your child when he/she is napping?

4. Eating Preferences:
What are your child's favorite foods?
Does your child use utensils, eat with fingers, feed self?
Does your child choke easily while eating?
<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Activities:
What activities do you like to do with your child?
What activities does your child like to do when playing with other children?
What does your child like to do when he is playing alone?

6. Family History:
Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)

I verify that the above assessment was discussed with the parent(s) of _____

Signature of Director

Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

Signature of Parent

Date Signed

Additional Comments:

brightwheel

Meet brightwheel, a window into your child's day

Our center has partnered with brightwheel, the leading early education technology, to help us deliver an enriching childcare experience to our students and families!

What you can expect from brightwheel

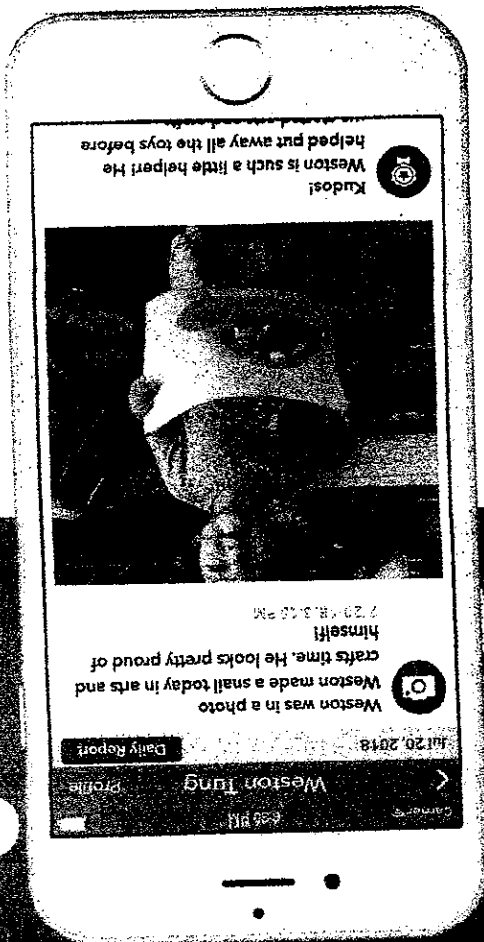
- More, real-time visibility into your child's day with photos, videos, and updates
- An easier way to stay connected to your child's learning and development
- A safer environment for our students and staff through contactless check-in/check-out, entry screens, and health checks
- Easy online tuition payments
- A single app for you to stay connected to all aspects of our center

What's next

Be on the lookout for an invitation to join our center on brightwheel! The invitation will include a link for you to set up your account. See you there!



"My son just started daycare and I was so nervous, but being able to see the pictures and different notes about him from the teacher and being able to message them back gives me peace of mind. I love it!"



Infant Sleep Exception/Health Care Professional Recommendation

When a health care professional determines that it is medically necessary for an infant to sleep in an alternative position (other than sleeping on the infant's back), sleep in a restrictive device (such as a bouncer seat or swing), or needs to be swaddled to sleep, use this form to ensure that a licensed child care center, licensed child care home, or registered child care home that cares for the infant meets the minimum standards required by Texas Human Resources Code §42.042(e)(8)(A) and (B). The standards for these operations require the operation to:

- follow the directions of an infant's health care professional to provide specialized medical assistance to the infant (746.3815 and 747.3615); and
- maintain, while active, this form and any other directions from the health care professional that the parent provides to the operation [See §746.603(a)(10) or §747.603(a)(9)]. Keep the exception form in the infant's classroom, so that a caregiver may refer to the health care professional's instructions.

Directions: This exception will not be effective until all sections and signatures are complete. Once completed, the exception is acceptable for use by the child care operation.

Infant's Information

Infant's Name		Date of Birth	Infant's Age	Parent/Guardian's Name
Address				
Home Phone	Work Phone	Fax	Email	

The infant's health care professional must complete the following section.

Health Care Professional Information

Name of Infant's Health Care Professional		Name of Practice
Address		
Work Phone	Home Phone	Email
		Fax number

The Texas child care minimum standards (§§746.2426, 746.2427 and 746.2428 for child care centers or §§747.2326, 747.2327 and 747.2328 for licensed or registered child care homes) require child care operations to place all infants on their backs to sleep in a crib and to ensure that infants do not sleep in restrictive devices and are not laid down to sleep swaddled. But, based on the advice of the infant's health care professional, when medically necessary, the center may be authorized to use an alternative sleep position, restrictive device, or swaddle for the infant due to medical reasons.

The above named infant has the following medical condition that necessitates an alternative sleep position, allow for sleep in a restrictive device, or requires swaddling for sleeping:

Health Care Professional Information

Please describe the appropriate sleep position/restrictive device/swaddling technique to be used for the above named infant and include the effective dates for the exception:

Effective Dates of Exception	From	To
------------------------------	------	----

Health Care Professional's Signature

Date

Waiver of Liability

- I affirm and acknowledge that the below named child care operation has provided me with the operation's safe sleep policy.
- I further authorize the child care operation and its caregivers to place my infant in an alternative sleep position, restrictive device, or swaddling at the recommendation of my infant's health care professional, as described above.
- I, as the parent or guardian of the above mentioned infant, release and hold harmless the below named child care operation, its officers, directors, caregivers, and employees from any and all liability whatsoever associated with harm to my infant due to Sudden Infant Death Syndrome (SIDS).

An authorized official with the child care operation must complete the following section.

Child Care Operation Information and Signature

Name of Child Care Operation	Operation Number
------------------------------	------------------

Parent or Guardian's Signature

Date Signed

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>.

Operation Representative's Signature

Date Signed



Operational Policy on Infant Safe Sleep

Form 2550
October 2019-E

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at Spirit's Heart Childcare Center and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Unexpected Infant Death (SIDS/SUIDS) at: <http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>

Safe Sleep Policy

All staff, substitute staff, and volunteers at Spirit's Heart Childcare Center will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415(b) and §747.2315(b)]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415(b) and §747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415(b) and §747.2315(b)].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2428 and §747.2328].

Privacy Statement

HHS values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>.

Signatures

This policy is effective on: _____ Child's name: _____

_____ Signature — Director/Owner	_____ Signature — Parent
_____ Date Signed	_____ Date Signed
_____ Signature — Staff member	_____ Signature — Parent
_____ Date Signed	_____ Date Signed



Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).
Directions: Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

Discipline and Guidance Policy

Discipline must be:

- 1) Individualized and consistent for each child;
- 2) Appropriate to the child's level of understanding; and
- 3) Directed toward teaching the child acceptable behavior and self-control.

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:

- 1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
- 2) Reminding a child of behavior expectations daily by using clear, positive statements;
- 3) Redirecting behavior using positive statements; and
- 4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:

- 1) Corporal punishment or threats of corporal punishment;
- 2) Punishment associated with food, naps, or toilet training;
- 3) Pinching, shaking, or biting a child;
- 4) Hitting a child with a hand or instrument;
- 5) Putting anything in or on a child's mouth;
- 6) Humiliating, ridiculing, rejecting, or yelling at a child;
- 7) Subjecting a child to harsh, abusive, or profane language;
- 8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
- 9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures (Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
 - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
 - (B) What behaviors would warrant the use of these measures; and
 - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date: _____

Signed by: _____

Role: Parent Caregiver/Employee Household Member (CH. 747 only)

Minimum Standards Related to Discipline

• Title 26, Chapter 746 Subchapter L: [http://texreg.sos.state.tx.us/public/readact\\$ext_ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readact$ext_ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y)

• Title 26, Chapter 747 Subchapter L: [http://texreg.sos.state.tx.us/public/readact\\$ext_ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readact$ext_ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y)

• Title 26, Chapter 744 Subchapter G: [http://texreg.sos.state.tx.us/public/readact\\$ext_ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y](http://texreg.sos.state.tx.us/public/readact$ext_ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y)