



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

Operation's Name Spirits Heart Childcare Center		Director's Name Angela Childress	
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	
Child's Home Address			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.	Custody Documents on File <input type="radio"/> Yes <input type="radio"/> No
Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached			Relationship
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		Phone Number	
Name		Phone Number	

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:

- | | |
|--|---|
| <input type="checkbox"/> Discipline and guidance | <input type="checkbox"/> Procedures for release of children |
| <input type="checkbox"/> Suspension and expulsion | <input type="checkbox"/> Illness and exclusion criteria |
| <input type="checkbox"/> Emergency plans | <input type="checkbox"/> Procedures for dispensing medications |
| <input type="checkbox"/> Procedures for conducting health checks | <input type="checkbox"/> Immunization requirements for children |
| <input type="checkbox"/> Safe sleep | <input type="checkbox"/> Meals and food service practices |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director | <input type="checkbox"/> Procedures to visit the center without securing prior approval |
| <input type="checkbox"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> Procedures for parents to contact Child Care Licensing (CCL), DFPS, 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

List 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

My 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:

1. 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

2. A signed and dated copy of a health care professional's statement is attached.
3. 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.
4. 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 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/ Pass 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

Signature

Date Signed

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)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
	12-15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6-18 months (third dose)	
	4-6 years (fourth 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.	
Measles, Mumps, Rubella	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.	

Physician or Public Health Personnel Verification

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

_____ Signature

_____ Date Signed

Varicella (Chickenpox)

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.

_____ Signature

_____ Date Signed

Additional Information Regarding Immunizations

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

TB Test (If Required)

Positive Negative Date: _____

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

Child's Parent or Legal Guardian

Date Signed

Center Designee

Date Signed



Operational Policy on Infant Safe Sleep

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/Sudden 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/Sudden 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].

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Signatures

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

Signature — Director/Owner

Date Signed

Signature — Staff member

Date Signed

Signature — Parent

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; humiliating, ridiculing, rejecting, or yelling at a child; subjecting a child to harsh, abusive, or profane language;
- 6) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
- 7) 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/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y)
- Title 26, Chapter 747 Subchapter L: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y)
- Title 26, Chapter 744 Subchapter G: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y)

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

Information on Health Checks

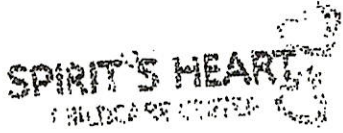
Documentation

- 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.

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/>.

X _____
Sign & Date



I _____ 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.

Signature: _____

Date: _____

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: _____



brightwheel

Meet brightwheel, a window into your child's day

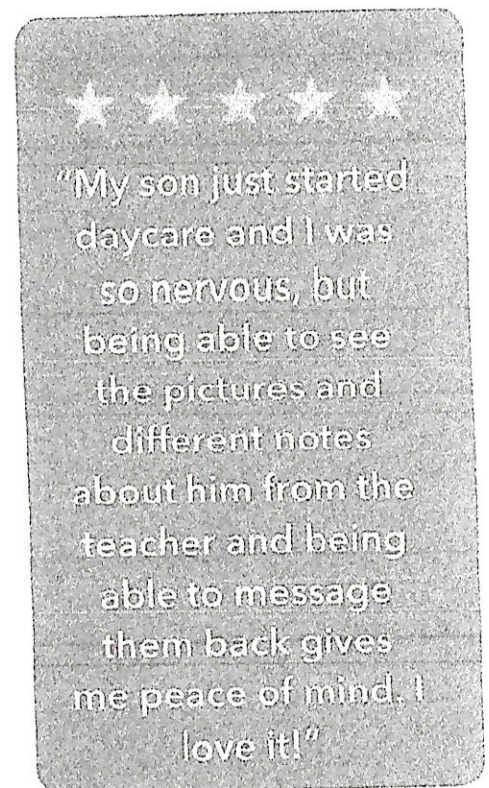
Our center has partnered with brightwheel, the leading early education technology, to help us deliver an enriching childcare experience to our students and families!

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!



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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. Toileting:

Does your child need assistance with toileting?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)	
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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:

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ADVANCE Child Care, Inc.

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Your child is enrolled in a center that 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 (FDPIR) 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 of 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 are 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, 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 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, 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. 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 the 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 Amy 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.

If you have other questions or need help, call Amy Pringle at (832) 282-1351.

Sincerely,
Advance Child Care, Inc.

CACFP Meal Benefit Income Eligibility Form
Letter to Household (Child Care Centers)

July 2011

Texas Department of Agriculture

Form H1625-A
March 2021

Income Eligibility Guidelines for Determining Free or Reduced-Price Benefits July 1, 2021 – June 30, 2022

Children from households whose incomes are at or below the levels shown below, 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 below, or who receive Medicaid, 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 que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa Suplementario de Alimentos en Reservas Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

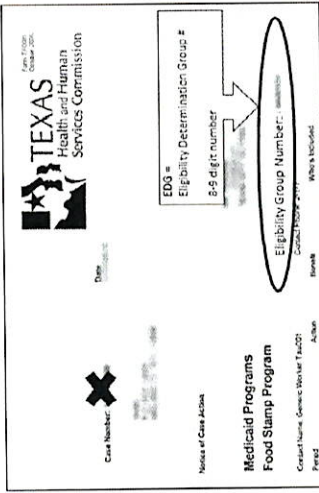
Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles mostrados a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas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

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
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	\$1,593	\$762
4	\$49,025	\$4,086	\$2,043	\$1,896	\$943
5	\$57,424	\$4,786	\$2,393	\$2,259	\$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	\$3,187	\$1,589
For each additional family member add:	\$8,399	\$700	\$350	\$324	\$162

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

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

- 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 FDPIR 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.

- 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, FDPIR, 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, FDPIR, 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 FDPIR:

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 FDPIR 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.

The illustration shows a portion of a form from the Texas Health and Human Services Commission. It includes the state logo and the text 'Form 17000 October 2005'. A 'Case Number' field is crossed out with a large 'X'. A 'Date' field is present. A 'Notice of Case Action' section lists 'Medicaid Programs' and 'Food Stamp Program'. A 'Contact Name' field is filled with 'Generic Worker Taa001'. A table at the bottom has columns for 'Period', 'Action', 'Benefit', and 'Who's Included'. A callout box points to the 'Eligibility Group Number' field, stating 'EDG = Eligibility Determination Group # 8-9 digit number'.

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.



Center Name Spirits Heart Childcare

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):		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
Names of all household members (First, Middle Initial, Last)			
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

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

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

A. Name (List only household members with income)	B. Gross income and how often it was received Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
<i>Example) Jane Smith</i>	\$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: _____
 City: _____ State: _____ Zip Code: _____
 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: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Mark one or more racial identities: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
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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:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-ComplaintForm-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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: (833) 256-1665 or (202) 690-7442;
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.



Building for the Future

This child care center receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program

Questions? Concerns?

Call USDA at
1-866-873-2263

Food and Nutrition at
1-800-TELL-TDA
(835-5832)

ADVANCE Child Care, Inc.
(903) 872-5231

Fraud Hotline: 1-866-5-FRAUD or 1-866-537-2834
P.O. Box 12847 Austin TX 78711
www.SquareMeals.org
USDA is an equal opportunity provider and employer.



Food and Nutrition Division | Child and Adult Care Food Program



TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

This product was funded by USDA. This institution is an equal opportunity provider.



Updated 12/2018

Join Texas WIC

We're here for you

"Thanks to WIC,
I now have the tools
I need to make
sure my family
stays on the path to
a healthy lifestyle."

—Roxie, WIC Client



As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	\$2,686	\$32,227
3	\$3,386	\$40,626
4	\$4,086	\$49,025
5	\$4,786	\$57,424
6	\$5,486	\$65,823

Effective May 1, 2021

* A pregnant woman's household is increased by the number of infants she is expecting. If you have any income questions, call 1-800-942-3678.

Start now. Call 1-800-942-3678 or visit TexasWIC.org



This institution is an equal opportunity provider.

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CACFP STUDENT ENROLLMENT

CM-1500

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 INFORMATION

Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Ethnic Identity (Check One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's First Name <input type="text"/>	Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander	
Child's Last Name <input type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>		
Normal Days in Care <small>Center's Days of Operation:</small> <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU		
Normal Hours in Care <small>Center's Hours of Operation:</small> <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
Meals/Snacks Child Receives <small>Meals/Snacks Served at Center:</small> <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS		
Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Ethnic Identity (Check One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's First Name <input type="text"/>	Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander	
Child's Last Name <input type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>		
Normal Days in Care <small>Center's Days of Operation:</small> <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU		
Normal Hours in Care <small>Center's Hours of Operation:</small> <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
Meals/Snacks Child Receives <small>Meals/Snacks Served at Center:</small> <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS		
Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Ethnic Identity (Check One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's First Name <input type="text"/>	Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander	
Child's Last Name <input type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>		
Normal Days in Care <small>Center's Days of Operation:</small> <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU		
Normal Hours in Care <small>Center's Hours of Operation:</small> <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
Meals/Snacks Child Receives <small>Meals/Snacks Served at Center:</small> <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS		

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

Parent First Name

Parent Last Name

Cell Phone

SITE / SPONSOR USE ONLY

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 (2) fax: (202) 690-7442; or (3) email: program.inlake@usda.gov. Office of the Assistant Secretary for Civil Rights: 1400 Independence Avenue, SW Washington, D.C. 20250-9410; This institution is an equal opportunity provider.

Infant Declaration Form:

Center Name _____

INSTRUCTIONS TO PARENTS:

Complete **BOTH** sections on this form. Sign and date where indicated. Submit to child care provider.

Section 1

Infant's Name _____ Birth Date: ____ / ____ / ____

Parent's Name _____

My child is allergic to the following foods:
(A Doctor's note is required for any foods that cannot be substituted within the same food group.)

Section 2

Your child care provider offers the following infant formula(s): _____

Parent Declaration - **Select only ONE of the following options.**


CENTER will provide ALL meal components for infant named above.

or

PARENT will provide ALL meal components for infant named above.

or

BOTH PARENT and CENTER will provide meal components for infant named above, as indicated below.

			0-5 Months	6-11 Months
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Iron Fortified Infant Formula / Breast Milk		<input type="checkbox"/>	<input type="checkbox"/>
	 _____	Infant Formula Brand Name		
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Iron Fortified Infant Cereal			<input type="checkbox"/>
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Infant Fruits/Vegetables			<input type="checkbox"/>
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Infant Meats			<input type="checkbox"/>
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Crusty Bread/Crackers			<input type="checkbox"/>

*** This form must be updated and submitted any time there is a change in Section 2.

I understand that once my infant child turns 6 months of age, it is my responsibility to notify the child care center director as to any limitations of solid foods that my infant child is not developmentally ready to receive.

Parent Signature

(____)____-____ / ____ / ____
Parent Phone Number

Date

*Please include your phone number so our CACFP Sponsor can contact you if they have any questions.

For Sponsor Use Only