

# Enrollment Agreement

# Learn N Play Academy

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

## Enrollment Information

*If your child is participating in school age child care, please complete form titled, "School Age Child Care Supplemental Enrollment Form."*

### Child's Information

Child's first name		Child's middle name		Child's last name		Child's nickname	
Age	Sex	Child's primary language		Parent/guardian/sponsor primary language			
Child's home address			City		State		Zip
Does your child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name		Grade		School phone	
School address			Drop off time			Pick-up time	

### Family Information

List family members & pets your child lives with – include first names, relation and ages of siblings

Parent/guardian/sponsor		Relationship to child		Home phone		Cell phone	
Home address if different from above			City		State		Zip
Home email		Work email			Work phone		
Employer	Employer address		City		State	Zip	Work hours
Other parent/guardian/sponsor		Relationship to child		Home phone		Cell phone	
Home address if different from above			City		State		Zip
Home email		Work email			Work phone		
Employer	Employer address		City		State	Zip	Work hours

### Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day.  
[For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pickup.]

<b>Person #1</b>		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Home email		Work email			Work Phone		
Employer	Employer address		City		State	Zip	Work hours
<b>Person #2</b>		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Home email		Work email			Work Phone		
Employer	Employer address		City		State	Zip	Work hours
<b>Person #3</b>		Relationship to child		Home phone		Cell phone	
Home address			City		State		Zip
Home email		Work email			Work Phone		
Employer	Employer address		City		State	Zip	Work hours

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

# Enrollment Agreement

# Learn N Play Academy

## Medical Information & Pre Entry Assessment Questionnaire

Child's name	Birth date	Height	Weight	Hair color	Eye color
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Distinguishing marks

### Child's Medical & Developmental History

- Does your child have any special medical conditions? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child have any chronic illnesses? ☐ No ☐ Yes Explain \_\_\_\_\_
- Please list a brief history of your child's serious injuries and hospitalizations. \_\_\_\_\_
- Does your child have diabetes? ☐ No ☐ Yes If yes, please attach care instructions from your physician.
- Does your child have asthma? ☐ No ☐ Yes If yes, please attach care instructions from your physician.
- Will medication be administered regularly? ☐ No ☐ Yes If yes, please attach care instructions from your physician.
- Does your child have any special dietary needs? ☐ No ☐ Yes Explain \_\_\_\_\_
- Is your child able to fully participate in all activities? ☐ Yes ☐ No Explain \_\_\_\_\_
- Does your child have any physical restrictions? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child function at the level of other children in his/her age group? ☐ Yes ☐ No Explain \_\_\_\_\_
- Is your child able to walk ☐ Yes ☐ No
- Can your child communicate his/her needs? ☐ Yes ☐ No
- Does your child need assistance at meal time? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child rest during the day? ☐ No ☐ Yes
- Is your child toilet trained? ☐ No ☐ Yes
- Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child require on-to-one care/supervision on a regular basis for a significant period of time? ☐ No ☐ Yes Explain \_\_\_\_\_
- Does your child require any accommodations or modifications to fully and equally enjoy and participated in a group care setting?  
☐ No ☐ Yes Explain \_\_\_\_\_

### Illness History (please check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Vision problems           | <input type="checkbox"/> Nosebleeds               | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Skin rashes              | <input type="checkbox"/> Mouth sores      |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Sore throats             | <input type="checkbox"/> Fainting         |
| <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Ear infections           | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Asthma/breathing problems | <input type="checkbox"/> Urinary track infections | <input type="checkbox"/> Other            |

Please attach care instructions from your physician for any of these illnesses.

### Disease History (please check all that apply and add the date)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chicken Pox (Varicella)  | <input type="checkbox"/> Bronchiolitis              | <input type="checkbox"/> Botulism                |
| <input type="checkbox"/> Measles Rubeola          | <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Haemophilus Influenza   |
| <input type="checkbox"/> Rubella (German Measles) | <input type="checkbox"/> Pertussis (Whooping cough) | <input type="checkbox"/> Meningococcal Infection |
| <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Tetanus                    | <input type="checkbox"/> Rabies                  |
| <input type="checkbox"/> Scarlet Fever            | <input type="checkbox"/> Diphtheria                 | <input type="checkbox"/> Bacterial Meningitis    |

### Allergies (please list)

- |                             |          |  |          |
|-----------------------------|----------|--|----------|
| <b>Medication Allergies</b> | Reaction | <b>Food Allergies</b>  | Reaction |
| _____                       | _____    | _____  | _____    |
| <b>Bee Stings Allergies</b> | Reaction | <b>Respiratory Allergies</b>   | Reaction |
| _____                       | _____    | _____  | _____    |
| <b>Other Allergies</b>      | Reaction | <b>Are any of these allergies life-threatening?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |          |
| _____                       | _____    |  |          |

Please attach care instructions from your physician for any life-threatening allergies...

### Miscellaneous Screenings and Tests (please check all that apply and add the date of last screening)

- |                                  |  |   |
|----------------------------------|--|---|
| <input type="checkbox"/> Vision  | <input type="checkbox"/> Developmental | <input type="checkbox"/> Tuberculosis (PPD) |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Aptitude      | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Speech  | <input type="checkbox"/> Educational   | <input type="checkbox"/> Other              |

To the best of my knowledge the information contained above is accurate.

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

# Enrollment Agreement

# Learn N Play Academy

## Medical Information (continued)

Child's name	Birth date
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### Child's Medical Care Provider

Primary physician's name	Primary physician's practice name	Phone
Physician's practice address	City	State Zip
Preferred hospital/clinic for emergency care	City	State
Dentist's name	Dentist's practice name	Phone
Dentist's practice address	City	State Zip

### Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number
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### Additional Medical Policies

1. Within 30 days of enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.	Initial
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.	
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious or is symptom free without medication for 24 hours.	
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 1 hour after being contacted. If I cannot be reached, the staff will contact those listed in the <i>Child Emergency Contact and Release</i> .	

### Emergency Medical Authorization & Consent

In case of a medical emergency, the staff will attempt to contact me, those listed in the <i>Child Emergency Contact and Release</i> , and lastly my physician.	Initial
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.	
In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.	
In case of a medical emergency, I will be responsible for the emergency medical expenses.	
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.	

I give my permission to this center to apply <input type="checkbox"/> sunscreen and <input type="checkbox"/> insect repellent to my child. <i>Please check which product you will permit.</i>	Initial
I understand that I must supply my own sunscreen and/or insect repellent with a valid expiration date, and it will be labeled with my child's name.	
I have special instructions for the application process. <input type="checkbox"/> None <input type="checkbox"/> _____	

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

# Enrollment Agreement

# Learn N Play Academy

## Rate Agreement and Contract

Child's name

Birth date

### Hours of Operation

Regular operating hours are Monday **through Friday from 6:30 AM to 6:30 PM** except closings for various holidays, and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures.

The procedure to notify families should severe weather or other conditions prevent the program from opening on time or at all will be announced on Fox 5 and facebook. If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release*, and it will be your responsibility to arrange for your child's early pick up.

### Fee Policy (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)

- Starting on \_\_\_\_\_ a fee of \$\_\_\_\_\_ is due WEEKLY

Initial

- Tuition is due and payable on Mondays,

- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), or absence other than hospitalization, contagious illness, or absence at the request of a doctor.

- I agree to pay the full tuition in advance of services rendered.

- I agree to pay the full tuition fee even if my child is absent for one or more days.

- A late fee of **\$25** is due if tuition is not received before Tuesday at 6:30

- A non-refundable registration fee of **\$75** due yearly.

- A late pick-up fee of **\$1** per minute per child (not to exceed **\$60** per child) is due if my child is not picked up before closing.

- Accounts two weeks in arrears may result in immediate termination of service.

- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip may be required.

- All returned checks or ACH transactions (automatic debits) will be charged a fee up to the maximum amount allowed by law. Two or more returned checks or ACH transactions will result in my account being place on "money order only" status.

- A receipt for income tax purposes will be provided.

## Other Agreements

### Private Employment Acknowledgement and Release

Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected or sanctioned by this center. This center shall remain harmless from any such arrangement.

Initial

### Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Initial

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

## Enrollment Agreement

# Learn N Play Academy

### Other Agreements *(continued)*

Child's name

Birth date

### Handbook Acknowledgement

I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.

Initial

I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.

Information contained in the **Family Handbook** may be subject to change.

### Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement* and the *Family Handbook*.

Primary Parent/Guardian/Sponsor Signature

Date

Center Staff Signature

Date

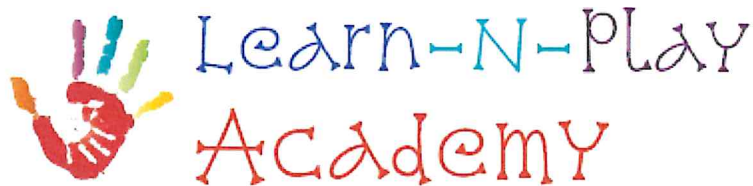
# School Age Child Care Supplemental Enrollment Form

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations.

Enrollment Information					
Child's Information					
Child's first name		Child's middle name		Child's last name	
Child's nickname					
Age	Sex	Child's primary language		Parent/guardian/sponsor primary language	
Child's home address			City	State	Zip
Does your child attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name		Grade	School phone
School address			Drop off time		Pick-up time
Child will be attending:		<input type="checkbox"/> Morning Care		<input type="checkbox"/> Afternoon Care	
Child will be attending:		<input type="checkbox"/> School Holiday Care		<input type="checkbox"/> Summer Care	

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date



### CONTRACT

1. Pay in advance for each week a tuition fee of \$ \_\_\_\_\_, with no deduction for holidays, vacation, or absences due to illness. Payment is due by the close of business each Tuesday, for the current week's tuition. A \$25.00 late charge per week will be added if tuition is not paid on time. If my child is out on any given week for any reason, I must give notice of the absence, and pay that week's tuition.
2. Pay a \$75.00 non-refundable registration fee at the time of enrollment and annually on May 1<sup>ST</sup> of each year.
3. Give LNPA a 2 weeks written notice of withdrawal. Payment for the 2 weeks is due as stated above if my child is withdrawn prior to the end of the 2 week notice for any reason.
4. A return check fee of \$30.00 will be charged for each check returned due to non sufficient funds. After the 2<sup>nd</sup> returned check, I will pay in cash only.
5. In the event of an emergency, accident, or illness, the center has my permission to administer medication or obtain emergency medical assistance as needed for my child's best interest. The center will seek emergency medical assistance at the nearest medical source subject to the nature of the emergency, accident, or illness. All medical expenses are the responsibility of the undersigned.
6. Should LNPA administration determine my child cannot adjust to the center's program, my child shall be withdrawn and the contract will be terminated.
7. All enrollment forms must be complete and on file prior to my child's first day of attendance. I will submit a current Immunization FORM 3231 within 2 weeks of enrollment and will submit an updated form on or before the date of expiration. My child cannot attend child care unless a current immunization form is on file.
8. I hereby warrant that I am entitled to legal custody and possession of my child(ren) and accordingly authorize my child(ren) to be placed in the care of the center and I am further authorized to sign this agreement. I understand all policies, rates, and fees are subject to change as condition warrant.

### STUDENT ACCIDENT INSURANCE

Our student accident insurance coverage is designed to work with your child's personal health care insurance. If there is an accident involving your child while at the center, you may request from the Director a Accident Claim Form. Learn N Play will file the claim on behalf of you and your child. Our main concern is the health and safety of your child. Please let us know if you have any questions concerning our student accident coverage.

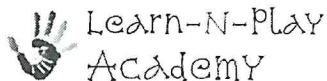
### **I UNDERSTAND ALL OF THE ABOVE**

Signature \_\_\_\_\_

Date \_\_\_\_\_

### PHOTO RELEASE

\_\_\_\_\_ I grant permission for Learn N Play Academy to record the participation and appearance of my child during school activities by photograph (we will never provide specific information about your child). Photos may be used in projects, newsletters, our website, social media page or advertisement. -IF YOU DO NOT AUTHORIZE, DO NOT INITIAL.



Childs Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### **Parental Agreement**

*Learn N Play Academy agrees to provide care for my child, January – December, Monday - Friday from 6am -6:30pm as specifically specified by the parent/guardian.*

My child will participate in the following meals at school

Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐

By initialing this form, I acknowledge that:

\_\_\_\_\_ LNPA opens at 6:30 am and closes at 6:30pm. If I do not pick up my child by 6:30pm, a fee of \$1.00 per minute will be added.

\_\_\_\_\_ Weekly tuition is due Tuesday before the close of business and a fee of \$25.00 will be added to my account if payment is not made on time.

\_\_\_\_\_ The tuition I pay each week maintains my child's spot at LNPA . Even when my child is absent, I still owe tuition to reserve my child's spot in the program. This applies to all programs.

\_\_\_\_\_ Annual Enrollment/Supply fees are \$75.00 per family and will be charged May 1 annually.

\_\_\_\_\_ I must give 2 weeks written notice if I choose to withdraw my child from LPA.

\_\_\_\_\_ If my child is sent home with a fever, vomiting or diarrhea, my child must be symptom/fever free for 24 hours before returning to school.

\_\_\_\_\_ LNPA will not give my child any over the counter medication unless directed by a physician in writing. All prescription medication must be in its original container and have a signed medication authorization completed.

\_\_\_\_\_ It is my responsibility to provide LNPA with an updated immunization record within the first 30 days of enrollment and any time the 3231 form expires.

\_\_\_\_\_ It is my responsibility to update my child's records in case of any changes (example: addresses, phone numbers, emergency contacts, pick up authorization etc)

\_\_\_\_\_ LNPA agrees to keep me informed of any illness, injury, adverse reaction to food/medication or incident, etc., concerning my child

\_\_\_\_\_ LNPA agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water activities occurring in water more than 2 feet deep.

\_\_\_\_\_ I authorize LNPA to obtain emergency medical care for my child when I am unavailable.

\_\_\_\_\_ I have received a copy and agree to abide by all policies and procedures for LNPA.

\_\_\_\_\_ I understand that the center will advise me of my child's progress and issues related to my child's care as well as any individual practices concerning my child's individual needs. I also understand that my participation is encouraged in facility activities.

### **PHOTO RELEASE**

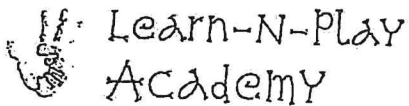
\_\_\_\_\_ I grant permission for Learn N Play Academy to record the participation and appearance of my child during school activities by photograph (we will never provide specific information about your child). Photos may be used in projects, newsletters, our website, social media page or advertisement. –IF YOU DO NOT AUTHORIZE, DO NOT INITIAL.

\_\_\_\_\_  
Parent/ Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Administrator

\_\_\_\_\_  
Date



**EMERGENCY MEDICAL CONSENT FORM**

LEARN N PLAY ACADEMY administration has my permission to obtain emergency medical treatment for my child, \_\_\_\_\_ when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

Mother/Guardian's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

My insurance provider is \_\_\_\_\_

My child's Insurance ID number is \_\_\_\_\_

Preferred hospital/treatment center \_\_\_\_\_

My child is taking the following medications

\_\_\_\_\_

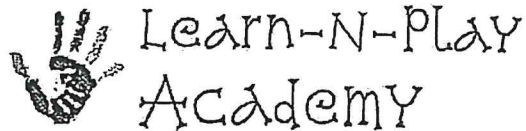
My child has the following allergies

\_\_\_\_\_

*If at anytime (due to such circumstances as accident, sudden illness or emergency) medical treatment is required, it may be given (including anesthesia if necessary), by a private physician or hospital.*

*I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in child care.*

\_\_\_\_\_  
Signature of Parent or Guardian Date



Authorization to Dispense External Preparations  
590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent. I give the staff at Learn N Play Academy, permission to apply one or more of the following topical ointments/preparations to my child

\_\_\_\_\_ ,  
in accordance with the directions on the label of the container.

\_\_\_\_\_ Baby Wipes  
\_\_\_\_\_ Band-aids  
\_\_\_\_\_ Neosporin or similar ointment  
\_\_\_\_\_ Bactine or similar first aid spray  
\_\_\_\_\_ Sunscreen  
\_\_\_\_\_ Insect Repellent  
\_\_\_\_\_ Non-Prescription ointment (such as A&D, Desitin,  
Vaseline)  
\_\_\_\_\_ Baby Powder  
Other (please specify)

\_\_\_\_\_  
Parent/Guardian Signature, Date  
\*maintain in child's file

# Learn N Play Academy

256 West May Street

Winder GA 30680

(770) 867-4996

[www.learnnplayacademy.com](http://www.learnnplayacademy.com)

## 2019-2020 Rates (as of 8/1/19 for New Students/Effective 9/1/19 for Enrolled Students)

### Private Preschool (year round)

Tots In Training (One's)	\$165/week
Jr. Preschool (Two's)	\$160/week
Preschool (Three's)	\$150/week
Private Preschool (Four's)	\$150/week

### PreK- 5<sup>th</sup> grade (max 12 years old) During School Year

After School	\$60/week
Before School	\$30/week
Before & After School	\$80/week
School Holidays Less than 3 days	\$20/day in addition to before/after school fee
3+days	\$150/week- includes food, & field trips
Unenrolled drop in students (at Administrators Discretion based on space) School Holidays *3 days or more is considered a full week	\$40/day \$150/week- during school year
Pre K Activity Fee	\$25/per school year

### Summer Care: PreK-5<sup>th</sup> Grade (max 12 years old)

Summer Camp: PreK-K	\$150/week
Summer Camp: 1 <sup>st</sup> -5 <sup>th</sup>	\$150/week
	Includes food & all field trips

### Other Fees

Annual Enrollment/Supply Fee	\$75 per family Due at time of enrollment & again by May 31 <sup>st</sup> of each year
Late Payment Fee	\$25 Added after 10:00 am Wednesday. <b>Tuition is due on TUESDAYS. NO exceptions</b>
Late Pick Up Fee	\$1/min/child after 6:30 pm

*I acknowledge that I understand and accept these fees.*

Signature \_\_\_\_\_ Date: \_\_\_\_\_



## CHILD AND ADULT CARE FOOD PROGRAM ENROLLMENT FORM

\_\_\_\_\_  
(Name of Child)      DOB \_\_\_\_\_ RACE \_\_\_\_\_

\_\_\_\_\_  
(Name of Facility)

\_\_\_\_\_  
(Address of Facility)

My child is normally in attendance at the facility between the hours of \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm on the following days (circle applicable days):

Sunday    Monday    Tuesday    Wednesday    Thursday    Friday    Saturday

My child will normally receive the following meals while in care (circle applicable meals/snacks):

Breakfast    AM Snack    Lunch    PM Snack    Supper    Evening Snack

Beginning on \_\_\_\_\_  
(Month/Day/Year)

\_\_\_\_\_  
Signature of Parent/Guardian      Date

\_\_\_\_\_  
Center Signature      Date

**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: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), 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](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

**Bright from the Start: Georgia Department of Early Care and Learning**  
**CACFP Meal Benefit Income Eligibility Statement\***

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

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. <b>Note:</b> Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
		Head Start	Foster Child	Migrant	Runaway	Homeless
		<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"/>	<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 II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)**  
**Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.**

**A. Child Income<sup>1</sup>** - Sometimes children in the household earn or receive income. Please indicate the TOTAL Child Income/How often? income received by child household members listed in PART I here. \$ \_\_\_\_\_ / \_\_\_\_\_

**B. Other Household Members<sup>1</sup>**. List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Welfare, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**C. Total Household Members (Adults and Children) listed in Part I and Part II** \_\_\_\_\_

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

Last four Digits of Social Security Number XXX-XX-\_\_\_\_ ☐ I do not have a Social Security Number

**PART III: Enrollment Information: *Children Only***

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

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

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

**PART IV: Signature**

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

Signature: **X** \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Check (✓) one ethnic identity: <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Not Hispanic/ Latino	Check (✓) one or more racial identities: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Indian or Alaska Native <input type="checkbox"/> Hawaiian or other Pacific Islander
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**Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12**

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

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

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

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

**Determining Official's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confirming Official's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Follow Up Official's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_