



## ENROLLMENT CHECKLIST

### Forms:

- ☐ ENROLLMENT FORM
- ☐ PARENT AGREEMENT
- ☐ PHOTO CONSENT FORM
- ☐ VEHICLE EMERGENCY FORM
- ☐ TRANSPORTATION AGREEMENT
- ☐ INFANT FEEDING PLAN
- ☐ AUTHORIZATION TO DISPENSE EXTERNAL PREPARATIONS
- ☐ SAFE SLEEP POLICY
- ☐ NOTICE OF NO LIABILITY INSURANCE
- ☐ INCOME ELIGIBILITY
- ☐ FOOD ALLERGY EMERGENCY CARE PLAN

### Paperwork To Bring:

- ☐ BIRTH CERTIFICATE
- ☐ COPY OF PARENTS DRIVERS LICENSE/ID
- ☐ COPY OF SS CARD
- ☐ IMMUNIZATION RECORDS

## **Supply Policy**

The following supplies are needed while your child attends Haven Center for Learning:

### **Infants**

- Diapers
- Wipes
- Premade Bottles (label with name and date daily)
- Change of clothes (bring in labelled ziplock bag)
- Ointment (Balmex, Aquafor, etc.)
- Infant food that is not supplied by HCFL
- Bulb syringe
- Infant Feeding Schedule (Form is Available from HCFL)

### **Toddlers**

- Diapers/Pull-ups/Training Pants
- Wipes
- Blanket for nap
- Change of clothes (bring in labelled ziplock bag)
- Sunscreen

### **Preschool**

- Blanket for nap
- Change of clothes (bring in labelled ziplock bag)
- Tennis shoes for outdoor play
- Sunscreen

### **School-age**

- Sunscreen
- Water bottle for field trips/park



**Now Enrolling 6 weeks - 12 yrs**

**Fee Schedule:**

Annual Registration \$75 per child

Annual Supply fee \$80 per family

Infants.....	\$200/week
1 year olds.....	\$200/week
2 year olds.....	\$185/week
3 year olds.....	\$175/week
4 years.....	\$175/week
Before or After School.....	\$75/week

Note: The Supply fee will be split into two payments.

782 Franklin Gateway Rd SE  
Marietta, GA 30067  
(678) 401-7372  
**GA CAPS Accepted**

# ENROLLMENT FORM

Page 1 of 3

Entrance Date \_\_\_\_\_ Withdrawal Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Home Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Father's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Mother's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

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

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

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

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)  
Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Relationship to Parent(s) or Guardian \_\_\_\_\_  
Other identifying information (if any) \_\_\_\_\_

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)  
Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Relationship to Parent(s) or Guardian \_\_\_\_\_  
Other identifying information (if any) \_\_\_\_\_

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

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

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

Child's doctor or clinic name \_\_\_\_\_

Doctor/clinic phone # \_\_\_\_\_

My child has the following special needs \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

## EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) \_\_\_\_\_ Date of birth \_\_\_\_\_

suffer an injury or illness while in the care of (Facility name) \_\_\_\_\_

and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: \_\_\_\_\_

Signature

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

Facility Administrator/Person-In-Charge \_\_\_\_\_

Signature

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

## Parental Agreements with Child Care Facility

Haven Center for Learning agrees to provide child care for:

\_\_\_\_\_ on \_\_\_\_\_ a.m. to \_\_\_\_\_ p.m.  
 (Name of Child) (Days of Week)  
 from \_\_\_\_\_ to \_\_\_\_\_  
 (Month) (Month)

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

Breakfast  
 Lunch  
 Afternoon Snack

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

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

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

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

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

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

I have received a copy and agree to abide by the policies and procedures for

Haven Center for Learning.  
 (Name of Facility)

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Parent/Guardian)

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



## Photography Consent Form

Our center likes to celebrate your child's work and achievements. As a result, images of your child and his/her work may appear on our website.

I, \_\_\_\_\_ (PRINT NAME)  
parent/guardian

of \_\_\_\_\_ (PRINT NAME)

hereby: grant permission / do not grant permission (delete as appropriate)

to Haven Center For Learning to take and use photographs and/or digital images of my child for use in printed publications or materials, electronic publications, school website and classroom displays for the duration of his/her time in the school.

SIGNED: \_\_\_\_\_

Date \_\_\_\_\_

SIGNATURE OF  
PARENT/GUARDIAN

## Transportation Agreement

This is to certify that I give \_\_\_\_\_  
Name of Facility

Permission to transport my child \_\_\_\_\_  
Name of Child

from \_\_\_\_\_ at \_\_\_\_\_ (am/pm)  
Pickup Location

to \_\_\_\_\_ at \_\_\_\_\_ (am/pm).  
Delivery Location

My child will be transported from \_\_\_\_\_ at \_\_\_\_\_ (am/pm)

to \_\_\_\_\_ at \_\_\_\_\_ (am/pm)  
Delivery Location

on the following days:

\_\_\_\_\_ Monday  
\_\_\_\_\_ Tuesday  
\_\_\_\_\_ Wednesday  
\_\_\_\_\_ Thursday  
\_\_\_\_\_ Friday

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The \_\_\_\_\_ is approximately \_\_\_\_\_ miles from the center.  
Location

In the event that my child is not to be transported as outlined above, I agree to notify the

\_\_\_\_\_.  
Facility

Signature (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_



## Vehicle Emergency Medical Information

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Father's Name \_\_\_\_\_

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

Mother's Name \_\_\_\_\_

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

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

Name \_\_\_\_\_ Phone \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Medical facility the center uses \_\_\_\_\_

Address \_\_\_\_\_

Child's Allergies \_\_\_\_\_

Current prescribed medication \_\_\_\_\_

Child's special needs and conditions \_\_\_\_\_

In the event of an emergency involving my child, and if \_\_\_\_\_

Name of Facility

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

Child's Name \_\_\_\_\_

Signature (Parent/Guardian) \_\_\_\_\_

Witness By \_\_\_\_\_ Date \_\_\_\_\_

## INFANT FEEDING PLAN

Child's Full Name \_\_\_\_\_ Date \_\_\_\_\_

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

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

Does the child eat: (check all that apply)

Strained Foods [ ] Whole Milk [ ]  
Baby Foods [ ] Table Food [ ]  
Formula [ ] Other [ ]

What type formula used, if applicable? \_\_\_\_\_

Amount and time of formula/breast milk to be given? \_\_\_\_\_ Date \_\_\_\_\_

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

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

### INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [ ] No [ ] Parent Initials: \_\_\_\_\_

The child has reached the following developmental skills:

Can hold his/her head steady? Yes [ ] No [ ]  
Opens mouth/leans forward in anticipation of food offered? Yes [ ] No [ ]  
Closes lips around a spoon? Yes [ ] No [ ]  
Transfers food from front of the tongue to the back and swallows? Yes [ ] No [ ]

Instructions for the introduction of solid foods \_\_\_\_\_

\_\_\_\_\_

Food likes \_\_\_\_\_

Food dislikes \_\_\_\_\_

Allergies? (including any premixed formula) \_\_\_\_\_

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN		
TIME	AMOUNT	TYPE

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

\_\_\_\_\_

**PARENT'S SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Authorization to Dispense External Preparations

### 590-1-1-.20(1)

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

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

\_\_\_\_\_ Baby Wipes

\_\_\_\_\_ Band-aids

\_\_\_\_\_ Neosporin or similar ointment

\_\_\_\_\_ Bactine or similar first aid spray

\_\_\_\_\_ Sunscreen

\_\_\_\_\_ Insect Repellent

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

\_\_\_\_\_ Baby Powder

Other (please specify) \_\_\_\_\_

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

\_\_\_\_\_  
Date

\*center should maintain in child's file

## Safe Sleep Practices Policy

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

### Safe Sleep Practices/Policies:

- 1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.
- 2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.
- 3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.
- 4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.
- 5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.
- 6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice: Blankets will be sent home on Fridays to be washed and returned on Monday.
- 7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.
- 8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.
- 9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

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

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

## **Parents or Guardian's Notice of No Liability Insurance and Acknowledgement**

I understand that I am being informed in writing by signing this acknowledgement that this facility, Haven Center for Learning, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

\_\_\_\_\_  
**Parents or Guardian's Signatures**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Guardian (Print Names)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Center Director's Signature**

\_\_\_\_\_  
**Date**

## AUTHORIZATION FOR MEDICATION

Child's Full Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescription Number: \_\_\_\_\_

Time Medication is to be given: \_\_\_\_\_

**(Medication will not be given on an "As Needed" basis, specifics must be provided)**

Amount of Medication to be given: \_\_\_\_\_

Dates to be given: \_\_\_\_\_

**(Not to exceed two weeks without a physician's statement)**

\_\_\_\_\_  
PARENT'S SIGNATURE

\_\_\_\_\_  
DATE

**FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc...)**

	<u>DATE</u>	<u>TIME GIVEN</u>	<u>AMOUNT</u>	<u>ANY ADVERSE REACTIONS</u>	<u>ADMINISTERED BY</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe:

**Attention to Person Requesting Medication Be Dispensed:**  
**Form must be completed in it's entirety before the center can dispense any**  
**medication**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

**PLACE  
PICTURE  
HERE**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

**THEREFORE:**

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:  
**SEVERE SYMPTOMS**



**LUNG**

Shortness of breath, wheezing, repetitive cough



**HEART**

Pale or bluish skin, faintness, weak pulse, dizziness



**THROAT**

Tight or hoarse throat, trouble breathing or swallowing



**MOUTH**

Significant swelling of the tongue or lips



**SKIN**

Many hives over body, widespread redness



**GUT**

Repetitive vomiting, severe diarrhea



**OTHER**

Feeling something bad is about to happen, anxiety, confusion

**OR A  
COMBINATION**  
of symptoms  
from different  
body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS



**NOSE**

Itchy or runny nose, sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives, mild itch



**GUT**

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE  
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM  
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

**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 FDIPIR 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:** \_\_\_\_\_



Dear Parent/Guardian:

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

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

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced-priced meals.).

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

If you checked no, fill out the form below.

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

For more information, you may call \_\_\_\_\_ at \_\_\_\_\_.  
CACFP Meal Benefit Income Eligibility Form Sharing Information with Medicaid/SCHIP.

# Infant Affidavit



Name of Sponsor (if applicable) \_\_\_\_\_

Name of Provider/Center \_\_\_\_\_

Name of Infant: \_\_\_\_\_

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

Name of Parent/Guardian:

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

Center/provider will provide the following milk-based iron-fortified formula: \_\_\_\_\_

Center/provider will provide the following Iron-fortified infant cereal: \_\_\_\_\_

Center/provider will provide the following brand of infant foods: \_\_\_\_\_

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Parents/Guardians,

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

\_\_\_\_\_ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

\_\_\_\_\_ I will provide the following meal component to my infant and the center will provide all other meal components:

☐ Formula\*

☐ Meat/Fish/Poultry/Eggs/Beans/Peas

☐ Cereal

☐ Cheese/Cottage Cheese/Yogurt

☐ Fruit

☐ Bread/Crackers/Breakfast Cereal

☐ Vegetable

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

\_\_\_\_\_  
Date

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

# WIC

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

### **WHO IS ELIGIBLE?**

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

### **SERVICES PROVIDED:**

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

### **TO BE ELIGIBLE, YOU MUST ALSO:**

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

### **APPROVED WIC FOODS:**

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

**YOU DO NOT HAVE TO BE  
ON PUBLIC ASSISTANCE  
TO APPLY.**

**CALL YOUR LOCAL HEALTH  
DEPARTMENT FOR MORE  
INFORMATION.**

# Georgia WIC Program

Georgia WIC  
Georgia Department of Public Health  
200 Piedmont Avenue, SE  
Atlanta, GA 30334  
Telephone: (404) 657-2700  
Website: <http://dph.georgia.gov/WIC>

## INCOME ELIGIBILITY GUIDELINES (Effective from July 1, 2025 to June 30, 2026)

Household Size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1 .....	28,953	2,413	1,207	1,114	557
2 .....	39,128	3,261	1,631	1,505	753
3 .....	49,303	4,109	2,055	1,897	949
4 .....	59,478	4,957	2,479	2,288	1,144
5 .....	69,653	5,805	2,903	2,679	1,340
6 .....	79,828	6,653	3,327	3,071	1,536
7 .....	90,003	7,501	3,751	3,462	1,731
8 .....	101,178	8,349	4,175	3,853	1,927
For each additional family member add	+ 10,175	+848	+ 424	+392	+ 196

[This institution is an equal opportunity provider.](#)

## CACFP Household Letter (Child Care Centers)

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Haven Center for Learning** 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 CACFP Meal Benefit Income Eligibility Form also known as the Income Eligibility Statement (IES). 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 an Income Eligibility Statement (IES) for each of my children in day care?** You may complete and submit one [1] IES 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: Haven Center for Learning; 782 Franklin Gtwy SE, Marietta, GA 30067; 678-401-7372.**
- 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) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.
- 3. Who can get reduced-price meals?** Your children can get reduced-priced meals if your household income is within the reduced-price limits on the Federal Income Eligibility Guidelines, shown on this application. Children in households participating in WIC may be eligible for reduced-price meals.
- 4. May I fill out a form if someone in my household is not a U.S. citizen?** Yes. 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's size on the attached Income Eligibility Guidelines, 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 receive overtime pay, include it, but not if you only work overtime on an occasional basis.

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 Income Eligibility Statement but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **GA DFACS**.
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, regarding 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. **Will the information I give be verified? (*pricing program only*)** Maybe. We may ask you to send written proof to verify the information you submitted on the form.
11. **What if I disagree with the decision about the information I complete on this form?** You should talk to your **Haven Center for Learning** director.

In the operation of the CACFP, 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 **678-401-7372**

Sincerely,

**Haven Center for Learning**