# 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

HAVEN
CENTER FOR LEARNING

## 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.....……..…… $165/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



**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…)**

| | DATE | TIME GIVEN | AMOUNT | ANY ADVERSE REACTIONS | ADMINISTERED BY |
|---|---|---|---|---|---|
| 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**

# FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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

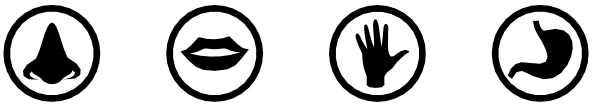
**OTHER**
Feeling something bad is about to happen, anxiety, confusion

**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): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

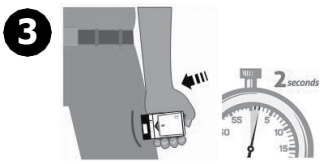
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

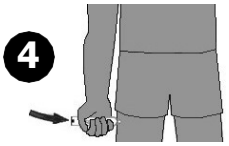
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



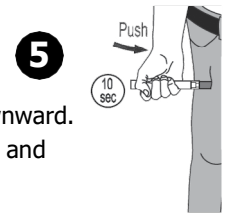

## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.




## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.




## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.


## HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.


## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

## EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

## OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

# 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. **Note**: Do not use EBT numbers. Write case number and proceed to Part III. | **Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply.** (See definitions in FAQs) | | | | |
|---|---|---|---|---|---|---|
| | | Head Start | Foster Child | Migrant | Runaway | Homeless |
| | | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | ☐ |

### PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
**Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.**

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

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

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

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

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

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

### PART III: Enrollment Information: *Children Only*
My child is normally in attendance at the facility between the hours of_____[am/pm] to_____[am/pm]. ☐ (✓) Check here if only before/after school care is provided.

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

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

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

**Signature:** X_____ **Print Name:**_____ **Date:** _____

**Address:**_____ **City:**_____ **State:**_____ **Zip:** _____ **Phone:** _____

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

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

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ Indian or Alaska Native ☐ Hawaiian or other Pacific Islander

**Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12**

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

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

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

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

**Determining Official's Signature**:_____ **Date**: _____

**Confirming Official's Signature**:_____ **Date**: _____

**Follow Up Official's Signature**:_____ **Date**: _____

The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits on the Annual Income Eligibility Guidelines.

| Household Size | Yearly Income |
|---|---|
| 1 | |
| 2 | |
| 3 | Please refer to the Income Eligibility Guidelines that are updated annually and available on DECAL's website. |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| Each additional person | Add: |

**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 your child for free or reduced-price meals. You must include the social security 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 SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: 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 mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov.

**This institution is an equal opportunity provider.**

**Sources of Income Chart[1]**

**INSTRUCTIONS**

| Sources of Income for Children | |
|---|---|
| **Sources of Child Income** | **Example(s)** |
| - Earnings from work | - A child has a regular full or part-time job where they earn a salary or wages |
| - Social Security<br>- Disability Payments<br>- Survivor's Benefits | - A child is blind or disabled and receives Social Security benefits<br>- A parent is disabled, retired, or deceased, and their child receives Social Security benefits |
| -Income from person outside the household | - A friend or extended family member regularly gives a child spending money |
| -Income from any other source | - A child receives regular income from a private pension fund, annuity, or trust |

| Sources of Income for Adults | | |
|---|---|---|
| **Earnings from Work** | **Public Assistance / Alimony / Child Support** | **Pensions / Retirement / All Other Income** |
| - Salary, wages, cash bonuses<br>- Net income from self-employment (farm or business)<br>If you are in the U.S. Military:<br>- Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances)<br>- Allowances for off-base housing, food and clothing | - Unemployment benefits<br>- Worker's compensation<br>- Supplemental Security Income (SSI)<br>- Cash assistance from State or local government<br>- Alimony payments<br>- Child support payments<br>- Veteran's benefits<br>- Strike benefits | ▪ Social Security (including railroad retirement and black lung benefits)<br>▪ Private pensions or disability benefits<br>▪ Regular income from trusts or estates<br>▪ Annuities<br>▪ Investment income<br>▪ Earned interest<br>▪ Rental income<br>▪ Regular cash payments from outside household |

**Households that receive SNAP, TANF, FDPIR, SSI or Medicaid: Complete the following:**

**Part I:** For family day care home and child care center, list participant's name and a SNAP, TANF, or FDPIR case number. For adult day care, list participant's name and a SNAP, TANF, FDPIR, SSI or Medicaid case number. **Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children. Note:** Children in Foster care, enrolled in Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Please refer to the Q&A section for a definition of each free categorical eligibility.
**Part II:** Skip this part.
**Part III**: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
**Part IV:** Sign the form.
**Part V:** Answer this question if you choose to.

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**All other Households, including WIC households, complete the following:**

**Part I:** For family day care home, child care center or adult day care, list participant's name.
**Part II:** To report total household income from last month, complete the following:
**A- Child Income**: Please indicate the TOTAL income received by **Child** household members listed in PART I. Please list any child income and how often it is received in this section.
**B – Adult Income:** List the first and last name of each **Adult** person living in your household as an economic unit. You must indicate yourself and all other adult members living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant should be listed here as well. Attach another sheet if necessary.
**List Gross Income.** Next to each person's name, list each type of income received last month, and how often it was received.
**B-Column 1**: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
**B-Column 2**: List the amount each person got last month from welfare, child support, alimony.
**B-Column 3**: List Social Security, pensions, and retirement.
**B-Column 4**: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
**Social Security Number:** If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or mark the "I don't have a Social Security Number" box.
**If no income:** If the person does not receive income from any source, write "0". If "0" is entered or any income field are blank, the person is certifying that there is no income to report.
**C – Total Household Members. Please list the total number of all household members (children and adults) in this section.**
**Part III**: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
**Part IV:** An adult household member must complete this section completely and then sign the form. Please refer back to Part II to ensure the last four digits of his/her social security number have been recorded or the box has been marked if he/she does not have one.
**Part V:** Answer this question if you choose to.

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

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## The Child and Adult Care Food Program

## Income Eligibility Statement Form and Supporting Documents

The United States Department of Agriculture (USDA) issued revised Income Eligibility Statements (IES) and other required forms to all state agencies to disseminate to institutions participating in the Child and Adult Care Food Program (CACFP). The newly revised IES package includes the following: IES form and instructions, reduced income guidelines template with privacy and non-discrimination statement, Sharing Information with Medicaid/SCHIP letter, sample house-hold letters based on program type, and template letters to use when verifying income and reporting the results of the verification. This newly revised IES application conforms to USDA's newly released prototypes and therefore meet all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

The revised IES package and supporting documents is available at http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP.

## Frequently Asked Questions

**Q. What information do I issue to parents?**

**A.** Institutions and facilities should issue the IES form, reduced income guidelines with the privacy and non-discrimination statement, appropriate household letter, and the Sharing Information with Medicaid/SCHIP letter to parents/guardians of children/adults participating in the CACFP.

**Q. Can centers/day care homes require parents/guardians to complete the IES form as part of the enrollment package?**

**A.** Centers/day care homes can **request** that parents/guardians complete the form as part of the enrollment process, but centers should **not require** parents/guardians to complete the form nor should they have policies/practices in place that negatively impacts the prospective/current participant's enrollment if the parent declines or fails to complete or submit the form. This action would be in violation of the Program.

**Q. Why is it necessary to issue the Sharing Information with Medicaid/SCHIP letter to parents?**

**A.** Parents/guardians that do not wish to have their information shared with either Medicaid or SCHIP must complete the form and return to facility. Otherwise and when requested by Bright from the Start or the United States Department of Agriculture (USDA), parent/guardian information will be shared with Medicaid/SCHIP.

**Q. Is it necessary to have three official's signatures on the new IES form-especially when the center is an independent center with only one staff person managing the CACFP?**

**A.** No. Only one signature is required for Independent centers with only one staff person responsible for managing the CACFP. However, institutions with more than one person managing the CACFP, and center and administrative sponsors are required to have a minimum of two signatures: **determining official and confirming official**.

**Q. What is the purpose of having a determining and confirming official signature?**

**A.** The confirming official will review the form and ensure accuracy and completeness. IES forms are considered current and valid until the last day of the month in which the form was dated on year earlier. The date to be used to make this determination is the date in which the sponsor or institution official signs the IES form to certify eligibility of the participant.

**Q. How long is the IES form considered current and valid?**

**A.** IES forms are considered current and valid until the last day of the month in which the form was dated one year previously. The date used to make this determination is the date in which the sponsor/ independent center official or parent/guardian signs the IES form. CACFP institutions and SFSP sponsors must decide which date they will use as the effective date and apply this date to all income eligibility forms submitted on behalf of all participants. CACFP institutions and SFSP sponsors are required to complete the **Income Eligibility - Effective Date Option Form.** In addition, institutions must indicate the options chosen in Section VIII. Recordkeeping (Item #2) of their Management Plan.

This means that sponsor and independent center officials should not request parent/guardians to complete IES forms at a specific frequency (e.g. start of each school year, every June, etc.). Request made by the sponsor or independent center official for IES form completion should be based solely on the expiration date of the IES forms.

**Q. Do I send a report to Bright from the Start listing parent/guardians that want their information shared with Medicaid/SCHIP?**

**A.** No. When instructed by USDA, Bright from the Start will request and collect data from institutions.

**Q. Can this form be used for children in childcare facilities and adults in adult daycare facilities?**

**A.** Yes.

**Q. Can siblings be listed on one form?**

**A**. Yes. Siblings from the same household can be listed on one form as long as there is space available.

**Q. When do I verify parent/guardian income?**

**A.** At the request of the United States Department of Agriculture (USDA), Bright from the Start, or any of its agents.

**Q. Where can I get copies of the IES form and supporting documents?**

**A.** Access Bright from the Start's webpage at http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP

**Q. Can I still participate in the CACFP if parents do not complete the IES form or do not return the form to my center?**

**A.** Yes. However, children that do not have IES forms on file must be placed in the "**paid**" category on the roster, which will effect monthly reimbursement. Centers that are using the IES form to capture annual enrollment information will be required to use an alternate enrollment form that captures at a minimum the name of the child, normal hours and days of care and meals the child usually receives while in attendance.

**Q. What if the form is completed by the parent but is not signed and dated by the sponsor or independent official. Is the form valid?**

**A.** The form would neither be current nor valid for free or reduced price meals since the signature and date of the sponsor or independent official is the certification of the eligibility of the participant.

**Q. Are households required to report changes in circumstances?**

**A.** No, Public Law 108-265 modified the requirements related to reporting changes in income during the period of eligibility covered by the application. Households are not required to report changes in circumstances, such as increase in income, a decrease in household size, or when the household is no longer certified eligible for benefits through Supplemental Nutrition Assistance Programs (SNAP) or Temporary Assistance for Needy Families (TANF).

**Q. Are temporary approvals (45 days) still required when no income is reported?**

**A.** No. Temporary approvals previously provided for short term assistance, such as when a household experienced a temporary income reduction or when no income was reported have been eliminated, are no longer required. Now, year-long eligibility includes households that report no income on their IES forms.

**Q. Can parents list some but not all of the household income received?**

**A.** No, the IES form requests all the household income including the frequency. By signing the IES form the parent/guardian certifies that all the information on the form is true and that all income is reported and that they understand that the center or day care home will receive Federal funds based on the information listed by the parent/guardian.

**Q. Do children participating in Head Start or Early Head Start need to complete additional income eligibility forms to qualify for free meals?**

**A.** Children enrolled in federal and state-funded Head Start or Early Head Start Programs are categorically eligible to receive free meal benefits without further application or eligibility determination. Categorical eligibility means Meal Benefit Forms are not required.

Eligibility determinations for the CNPs are made on an annual basis. As long as the child is enrolled in Head Start or Early Head Start at the time the annual eligibility determination is made, all reimbursable meals served to that child may be claimed at the free rate.

Institutions, sponsors, and school food authorities may establish eligibility of all Head Start enrollees through documentation provided by the Head Start program. Forms of acceptable documentation include:

- Approved Head Start application
- Statement of Head Start enrollment
- List of participants from a Head Start official

**Q. If a child who is eligible for Head Start benefits also attends a child care center or day care home, is the child automatically eligible for free CACFP meals at the child care facility without further application or eligibility determination?**

**A.** Yes. All CACFP reimbursable meals served to children enrolled in Head Start or Early Head Start may be claimed at the free rate by child care centers or at Tier I rates in day care homes in which they are enrolled. Documentation of acceptable Head Start eligibility must be maintained.

**Q. Are the siblings or other children who are members of a Head Start child's household also automatically eligible for free meals without further application?**

**A.** Only children enrolled in Head Start are categorically eligible. Categorical eligibility based on Head Start enrollment does not extend to all children in the same household.

**Q. Can a day care home document its eligibility for Tier I reimbursement based on the provider's own child's enrollment in a Head Start program?**

**A.** The Improving Head Start for School Readiness Act of 2007 (Public Law 110-134) extended categorical eligibility only to children enrolled in Head Start; therefore, a child's Head Start enrollment does not extend to the provider.

**Q. Are children who are enrolled in Head Start, but who are members of households that are above the Head Start income eligibility requirements, still eligible for CACFP meals at the free rate?**

**A.** Yes. All reimbursable meals served to children enrolled in Head Start may be claimed at the free rate. Head Start serves primarily children from families with household incomes at or below the federal poverty level. However, a small proportion of children in families with household incomes above the poverty level may also be served.

Public Law 110-134 amended sections 9(b)(12)(A)(iii) and 17(c)(5) of the Richard B. Russell National School Lunch Act to make any child enrolled in Head Start categorically eligible for free meals without further application or eligibility determination.

**Q. Are children enrolled in state-funded prekindergarten programs eligible for free meals?**

**A.** Children participating in state-funded prekindergarten programs are not automatically eligible for free meals. In California, the income eligibility requirements for state-funded preschools are less stringent than the requirements for the Head Start Program. Therefore, determinations of eligibility for free meals for participants must be made on an individual basis.

**Section 107 of the Child Nutrition and WIC Reauthorization Act of 2004 (Act) amended section 9(b) of the Richard B. Russell National School Lunch Act to make runaway, homeless and migrant children categorically eligible for free meal benefits under the National School Lunch and School Breakfast Programs and is effective July 1, 2004.**

**Q. What is the definition of homeless?**

**A.** The term "homeless children" has the meaning given to "homeless children and youths" in section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)).

"Homeless children" means:

1. Individuals who lack a fixed, regular, and adequate nighttime residence; and

2. Includes -

    a. Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; are

living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

b. Children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

c. Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

d. Migratory children who qualify as homeless because they are living in circumstances described in a-c above.

**Q. What is the definition of migrant?**

**A.** Migrant family means, for purposes of CACFP eligibility, a family with children under the age of compulsory school attendance who changed their residence by moving from one geographic location to another, either intrastate or interstate, within the preceding two years for the purpose of engaging in agricultural work and whose family income comes primarily from this activity.

**Q. What is the definition of runaway youth?**

**A.** The term "runaway", used with respect to a youth, means an individual who is less than 18 years of age and who absents himself or herself from home or a place of legal residence without the permission of a parent or legal guardian. https://definitions.uslegal.com/r/runaway-youth

**Q. What is the definition of Foster care?**

**A.** Foster care means 24-hour substitute care for children placed away from their parents or guardians and for whom the state agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child-care institutions, and pre-adoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the state or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is federal matching of any payments that are made.

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.