Kicklighter Academy

Enrollment Application

The mission of the Kicklighter Resource Center, Inc. is to improve the quality of life of children and adults with autism and other developmental and physical disabilities through advocacy, community awareness, family support, and direct programs.

Administration

Director
Stacey Davis

Assistant Director
Jay Ahnee

Contact Information

Physical Address
7219 Seawright Drive
Savannah, GA 31406

Mailing Address
PO Box 13625
Savannah, GA 31406

912-355-7633 phone
912-355-4206 fax

Email: info@krc.org

Website:
krcacademy.org

Kicklighter Academy

New Student Enrollment Checklist

Child's Name: _____ Enrollment Date:_____

FORM	DATE RECEIVED	INITIALS
Enrollment Information		
Financial Agreement (Ms. Janice)		
CACFP/IES Form (Meal Reimbursement)		
Emergency Information (2 copies)		
Promotional Release		
Initial Payment Information		
Feeding Chart (if needed)		
Questionnaire for teacher		
Immunization Record (GA form 3231)		
Intake Process (if required) ◯ Yes ◯ No		
Scheduled Tour Date (required): _____		

Kicklighter Academy

Parent/Legal Guardian Agreement

I/We, _____ the parent(s)/legal guardian(s) of _____, agree to the following:
(child's name)

(Please Initial)

_____ I have received and read a copy of the Parent Handbook.

_____ Abide by the tuition payment schedule as stated in the Parent Handbook.

_____ Abide by the established school calendar included in the Parent Handbook.

_____ Communicate with my child's teacher and attend parent/ teacher conferences.

_____ Attend a minimum of two (2) Parent Teacher Council Meetings per year.

_____ Pick up my child's communication folder from his/her classroom every Friday afternoon (or the last day of the week) and return the folder to the teacher on Monday morning.

_____ Submit a two-week written notice of intent to withdraw student to the Director or remit two weeks of the current tuition as a withdrawal fee.

_____ Submit a two-week written notice of intent to withdraw student to the Director or remit two weeks of the current tuition as a withdrawal fee.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Kicklighter Academy

Privacy Notice

Kicklighter Resource Center, Inc. is licensed by Bright from the Start Georgia Department of Early Care and Learning, ("Department") to operate a CHILD CARE LEARNING CENTER named as Kicklighter Academy. As such, the center must adhere to the Rules for Child care Learning Centers adopted by the State of Georgia and Department.

This license is granted pursuant to the authority vested in Bright from the Start: Georgia Department of Early Care and Learning, O.C.G.A. §20-lA-1, and signifies that the center complies with applicable rules.

By signing this document, you acknowledge you have been informed that:

1) Georgia Department of Early Care and Learning, Bright from the Start and its representatives are authorized and empowered to conduct on-site inspections and investigations of centers.[1]

2) Pursuant to an investigation conducted by Georgia Department of Early Care and Learning, a Bright from the Start representative may enter the premises at any time during operating hours for the purpose of inspecting the facility, including having the authority to be given meaningful access to all children present and all records required by these rules.[2]

(i) "Meaningful access" as interpreted by the Department includes interviewing all children present at the time of the investigation by the representative.

(ii) "Meaningful access" as interpreted by the Department does not require permission of the parent or legal guardian prior to interviewing any child by a representative.

3) Pursuant to an investigation conducted by the Department your child's records may be reviewed by a Bright from the Start representative and a copy made for purposes of the investigation. [3]

Every effort will be made by the administration of Kicklighter Academy to inform you prior to your child being interviewed; however, failure to contact you does not prevent access to your child or his/her records. You will be notified by Kicklighter of any interview conducted with your child.

Parent(s) and/or legal guardian(s) must sign acknowledging that they have been advised of these rules and that they have received a copy of the same. A signed acknowledgment is required for participation by your child in this licensed child care learning center.

_____ _____

Signature of Participant's Parent or Legal Guardian Date

_____ _____

Signature of Participant's Parent or Legal Guardian Date

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[1] 591-1-1.37 "Inspections and Investigations," *Rules for Child Core Learning Facilities.*
The Department is authorized and empowered to conduct on-site inspections and investigations of centers.

[2] 591 1-137(b) Consent to Entry. An application for a license to operate a center or issuance of a license by the Department constitutes consent by the applicant, the proposed holder of the license and the owner of the premises for the Department's representative after displaying identification to any center staff to enter the premises at any time during operating hours for the purpose of inspecting the facility, including both scheduled and unscheduled inspections and includes consent for meaningful access to all staff, parts of the premises, all children present and all records required by these rules to be maintained and needed for any inspections or investigation.

[3] 591 1-137(b) Consent to Entry. The Department shall have the right to photocopy or reproduce by any means any records required by these rules to be maintained and needed for any inspections or investigation.

Kicklighter Academy
Enrollment Information

PLEASE PRINT **DATE** _____

How did you hear about us? ☐ Radio ☐ Website/Internet ☐ Social Media ☐ TV ☐ Newspaper ☐ From a friend

CHILD'S INFO

Child's Name _____ DOB _____ Age _____ Gender ☐ M ☐ F
Nickname (if Applicable) _____
Child's Home Address

_____ _____ _____ _____ _____
Street City State Zip County

PARENT INFO

Mother's Name _____
Home Address (if different from child)

_____ _____ _____ _____ _____
Street City State Zip County
Home Phone _____ Cell Phone _____ Alternate Phone _____
Place of Employment _____
Work Phone _____ Email Address _____

Father's Name _____
Home Address (if different from child)

_____ _____ _____ _____ _____
Street City State Zip County
Home Phone _____ Cell Phone _____ Alternate Phone _____
Place of Employment _____
Work Phone _____ Email Address _____

Legal Guardian

Child's Living Arrangement: ☐ Both Parents ☐ Mother ☐ Father ☐ Other
Child's Legal Guardian (if not parents) _____
Legal Guardian's Address _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____

Emergency Contact (If parent/guardian cannot be reached)

Name _____ Relationship to child _____
Address _____
Home Phone _____ Cell Phone _____ Work Phone _____

FOR OFFICE USE ONLY

Child's Start Date _____ Enrollment Fee _____ Date Paid _____
Classroom _____ Annual Tuition _____ EIBI Student ☐ Yes ☐ No
(☐ Monthly Billing Cycle _____ ☐ Weekly Billing Cycle _____
Payment Type ☐ Cash ☐ Check (enter required Driver's License Number _____
☐ Credit or Debit Card (see attached authorization form)
Copy to Finance Office _____ Date _____ Staff Initials _____

Kicklighter Academy

Additional Student Information for Classroom Teacher

Child's Name _____ Date of Birth _____

General Growth and Development

Does your child have a documented developmental disability? ◯ Yes ◯ No

If yes, select from the following:

☐ Autism ☐ Down Syndrome ☐ Cerebral Palsy ☐ Developmental Delay ☐ Other_____

Eating

Favorite Foods _____

Non-preferred Foods _____

Can eat independently with a spoon? ◯ Yes ◯ No With a fork? ◯ Yes ◯ No

Can eat finger foods appropriately? ◯ Yes ◯ No

Can drink independently from an open cup? ◯ Yes ◯ No

Language and Communication

List any speech difficulties _____

_____

How does your child communicate his/her wants and needs?

☐ Cries ☐ Points ☐ Stands by objects ☐ Pulls others to objects

☐ Uses 1-5 words or signs ☐ Uses 5-10 words (or signs)

Frequently asks for desired items/objects using clearly understandable words? ◯ Yes ◯ No

Will follow a few instructions related to daily routines? ◯ Yes ◯ No

Can follow many instructions and identify at least 100 items, actions or persons? ◯ Yes ◯ No

Can verbally identify items, actions, or persons (select appropriate quantity) ☐ 1-5 ☐ 6-25 ☐ 26-100

Can fill in words and/or phrases to songs? ◯ Yes ◯ No

Favorite songs _____

Behavior and Social Interaction

Does your child display any chronic behavioral challenges? ◯ Yes ◯ No

If yes, please describe _____

_____

How often does these chronic behaviors occur? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other

How does your child initiate and sustain interactions with others? _____

_____

How does he/she adjust to new situations? _____

Are there brothers and/or sisters at home? _____

Extended family or other household members? _____

Pets?_____

Toileting

Is your child independent with toileting procedures? ◯ Yes ◯ No

If no, which procedures require assistance? _____

How does he/she indicate toileting needs? _____

How does he/she indicate wet/soiled diaper or clothing?_____

Sleeping

Does your child take naps? ◯ Yes ◯ No Your child's normal nap schedule _____

Does he/she sleep with a certain object? ◯ Yes ◯ No

Special comfort required when waking from nap? _____

Kicklighter Academy
Child Medical Information

Important Medical Information

Child's Name _____ DOB _____ Age _____ Gender ___M ___F

List all food allergies

Food Allergy	Reaction

List all medication allergies

Medication Name	Reaction

Other allergies (e.g. insect bites, pet dander, dust, etc.)

Allergen Type	Reaction

Special Dietary Needs and/or Dietary Restrictions

_____

_____

List all medication that will be administered at Kicklighter (include medication name, dosage, and time). Only medication in its original container will be accepted/administered.

Medication	Dosage	Time to be Given

Physician and Insurance Info

Physician's Name _____	Physician's Phone Number _____
Physician's Practice/Clinic Name and Address	Preferred Hospital for Emergency Care
Primary Health Insurance Provider Name and Policy Number	Secondary Health Insurance Provider Name and Policy Number

Kicklighter Academy

Permission for Emergency Medical Treatment

Major injuries and/or illnesses that arise during school hours will be evaluated by the Academy Director. Parents/Guardians of injured or ill students will be notified immediately by telephone. When parents/guardians are unable to be contacted, the designated emergency contact will be notified. In the event we cannot reach the parent or the designated representative we will act on your behalf in the best interest of the injured/ill student. If emergency attention is required, the student will be transported via ambulance to Memorial Health University Medical Center Emergency Room at 4700 Waters Avenue Savannah, Georgia, for evaluation. Attempts to notify parents/guardians will continue and Kicklighter Academy staff will remain with the student until the parents/guardians arrive. It is necessary that all parents/guardians are aware of this policy.

I _____ parent/guardian of _____
(parent/guardian's name) (child's name)

have read and am aware of the Kicklighter Academy policy on medical emergencies. In the event of injury or illness to my son, daughter, or ward, I hereby authorize and direct a Kicklighter Academy supervising staff member to secure medical treatment, including, but not limited to, hospitalization, injections, anesthesia, and surgery; thereby authorizing a Kicklighter Academy supervising staff member to sign and consent thereto as fully as I could were I personally present. As a parent or guardian of the student, I further agree to indemnity and hold harmless The Kicklighter Resource Center, Inc. (owner/operator of Kicklighter Academy) and any adult supervising staff members who have acted on my behalf from any damages recovered or recoverable by my son, daughter, or ward .

I agree to keep Kicklighter informed of any changes in address, work place, telephone numbers, etc. where I can be reached.

My child's primary source of health care is:

_____ _____
Physician's Name Phone Number

_____
Physician's Address

_____
Medical Insurance Provider and policy number

_____ _____
Parent/Guardian Signature Date

In the event of a medical emergency and I cannot be reached, please contact

Name_____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Kicklighter Academy
Promotional Release

Child's Name _____

I hereby agree and consent to participate in the taking and use of pictures, film, audio, or other promotional materials for publicity purposes by The Kicklighter Resource Center, Inc. and Kicklighter Academy. I waive all claims for compensation for such use. This release shall be valid for any and all purposes listed above unless terminated by written notice.

_____
Parent/Guardian Name Print

_____
Parent/Guardian Name Signature

_____
Date

Kicklighter Academy

Authorization to Charge Debit/Credit Card

I, _____request that you automatically charge my debit/credit card for tuition due for my child/children at Kicklighter Academy. I understand that my debit/credit card information will be stored in a locked, secure environment.

_____ _____

Student Student

Bill my debit/credit card: ___ Weekly (billed on Tuesday of each week)
___ Monthly (billed on the 1st day of each month)

Amount to bill $ _____ Date to begin billing debit/credit card _____

Card Type ___ Debit ___ Credit [___ MasterCard ___ Visa ___ Other _____]

PLEASE PRINT CLEARLY

Name as it appears on card _____

Card Number _____ Security Code _____

Expiration Date _____ Billing Zip Code _____

I understand that by signing this authorization form, The Kicklighter Resource Center, Inc. will bill my debit/credit card as indicated above. My debit/credit card will be billed as requested and I must contact the finance office at The Kicklighter Resource Center, Inc. within two (2} business days to cancel a scheduled charge to the debit/credit card.

I further understand that in the event the debit/credit card transaction is declined, it will be my responsibility to make sure the current payment is made by the due date or I will be charged the standard late fee of $25.

_____ _____

Signature of Card Holder Date

_____ _____

Phone Number Alternate Phone Number

Kicklighter Academy

Parental Agreements with Child Care Facility

1. The **Kicklighter Academy** agrees to provide childcare for _____
(child's name)

   on ☑ Mon ☑ Tues ☑ Wed ☑ Thurs ☑ Fri from 7:00 AM to 6:00 PM
   (select all days which apply)

   from JULY (beginning month) to JUNE (ending month).

   Select applicable meals and snacks
   ☑ Breakfast ☑ Lunch ☑ Afternoon Snack

2. 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, dosage, date, and time of day medication is to be given. Medicine will be in the original container labeled with my child's name.

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

4. 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.

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

6. The **Kicklighter Academy** 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.

7. I have received a copy of this form and agree to abide by the policies and procedures for **Kicklighter Academy**.

_____ _____
Signature (Parent/Guardian) Date

_____ _____
Signature (Facility Administrator) Date

Kicklighter Academy
Student Pick-Up Authorization

Student _____ Date _____

The individuals listed below are authorized to pick up the student listed above. This list can only be altered or modified by the student's parent/guardian in writing and when accompanied by an original signature.

Parent/Guardian 1 Relationship to Student

_____ _____

Home Number _____ Cell Number _____ Work Number _____

Parent/Guardian 2 Relationship to Student

_____ _____

Home Number _____ Cell Number _____ Work Number _____

Authorized Person 1 Relationship to Student

_____ _____

Home Number _____ Cell Number _____ Work Number _____

Authorized Person 2 Relationship to Student

_____ _____

Home Number _____ Cell Number _____ Work Number _____

Authorized Person 3 Relationship to Student

_____ _____

Home Number _____ Cell Number _____ Work Number _____

Authorized Person 4 Relationship to Student

_____ _____

Home Number _____ Cell Number _____ Work Number _____

Parent Signature _____ **Date** _____

Building for the Future

Meals

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to enrolled participants receiving care. Providers receive monetary reimbursement for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.
CACFP homes and center follow meal requirements established by the USDA.

Breakfast	Lunch or Supper	Snacks (2 of the 4 groups)
Milk (Whole or 1%) Fruit or Vegetable Grains or Bread	Milk (Whole or 1%) Meat or Meat Alternative Grains or Bread 2 different servings of Fruits or Vegetables	Milk (Whole or 1%) Meat or Meat Alternative Grains or Bread Fruit or Vegetable

Participating Facilities

Many different homes and centers operate the CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- Child Care Centers: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- Adult Care Centers: Public or private non-profit and some for-profit centers.
- Family Day Care Homes: Licensed or approved private child care homes.
- Afterschool Care Programs: Centers in low-income areas providing free snacks to school age children and youth.
- Emergency/Homeless Shelters: Shelters that provide residential and food services to homeless children. Shelters are the only residential programs that may participate.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following:

- Children age 12 and under;
- Migrant children age 15 and under;
- Youths through age 18 in afterschool care programs in needy areas;
- Chronically impaired disabled adults 18 years of age or older; or
- Persons 60 years of age or older in a group setting outside their home.

Contact Information

This center participates in the CACFP under the sponsoring organization listed below. The CACFP is administered in every state and in Georgia by the agency listed below. Contact one of the following for questions or more information about the CACFP.

Sponsoring Organization/Center:
Dr. Brenda C. Weitman, Director
Georgia Child Care Resources, Inc. PO Box 1026
203 S Laurel Street, Suite 201
Springfield, GA 31329
Ph:912-657-4806
bcweitman@aol.com

State Agency:
Nutrition Services Director
Bright from the Start
GA Dept of Early Care and Learning
10 Park Place South, Suite 200
Atlanta, GA 30303
Ph:404-656-5957
www.decal.state.ga.us

Georgia Child Care Resources, Inc.
203 South Laurel Street, Suite 202
PO Box 1026
Springfield, GA 31329

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Kicklighter Academy offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine If your child(ren) qualifies for free or reduced-price meals.

1. **Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household only if the children In child care are enrolled in the same center. We cannot approve a form that is not complete so be sure to read the instructions carefully and fill out all required Information. Return the completed form to: Kicklighter Academy.
2. **Who can get free meals without providing income information?** Children in households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in an HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete
the CACFP Meal Benefit Income Eligibility Form.
3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduce price limits on the Income
Chart sent with this application. Children in households participating in WIC may be eligible for reduced price meals.
4. **May 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 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 Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you
missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals.
Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 208SFC, Placement Authorization Foster Care/Residential Care, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.
9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
10. **What if I disagree with the decision about the information I complete on this form?** You should talk to your Center or Sponsoring Organization director.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability. If you have other questions or need help, call 912-754-9936.

Brenda C. Weitman, EDD
Director, GA Child Care Resources, Inc.

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 (including yourself) not listed in Part I even if they do not receive income. 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 7 [am/pm] to 6 [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: [redacted] **Monday Tuesday Wednesday Thursday Friday** [redacted]

Circle the meals your child will normally receive while in care: **Breakfast** [redacted] **Lunch PM Snack** [redacted] [redacted]

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 ☐ Month ☐ Year **Household Size**: _____

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

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**: _____

SHARING INFORMATION WITH MEDICAID/SCHIP

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-price 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.

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 child less than five years old

SERVICES PROVIDED:

- Nutritious Foods
- Nutrition Counseling
- Breastfeeding Support
- Health Care Referrals

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 INCLUDE:

Milk • Cheese • Eggs • Cereals • Peanut Butter • Fruit & Vegetable Juices • Dry Beans & Peas • Iron-fortified Formulas

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

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.