

Enrollment Agreement

Kids Come First Early Learning Centers #2

297 Shannon Way | Lawrenceville, GA 30044 | Ph: 770.513.0380 | Fx: 678.609.5311

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

Enrollment Information

Child's Information

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

Family Information

PRIMARY Parent/guardian		Relationship to child		Home phone		Cell phone			
Home address if different from above				City		State		Zip	
Home email			Work email			Work phone			
Employer		Employer address		City		State		Zip	Work hours
OTHER Parent/guardian		Relationship to child		Home phone		Cell phone			
Home address if different from above				City		State		Zip	
Home email			Work email			Work phone			
Employer		Employer address		City		State		Zip	Work hours
Who is enrolling the child?				If other, enrolling person's name:			Parents are: Single/Married/Divorced/etc		
Who is responsible for payment?				If other, responsible person's name:			Is there any custody agreement?		

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

The people designated in this section will be contacted by us if you cannot be reached in the event of an emergency. Our staff will only release your child to you or to the people listed below. Please notify the center in advance when an Emergency Release Contact will pick up your child. If you want a person who is not listed below to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization. All authorized pick-up persons with whom staff is not familiar must provide a photo ID at the time of pick up.

Person #1		Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip
Home email			Work email			Work Phone		
Person #2		Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip
Home email			Work email			Work Phone		
Person #3		Relationship to child		Home phone		Cell phone		
Home address				City		State		Zip
Home email			Work email			Work Phone		

Parent initial _____ Staff initial _____ Date _____

Medical Information

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

Child's Medical & Developmental History

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

Illness History (please check all that apply)

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

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

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

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

Allergies (please list)

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

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

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

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

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

Parent initial _____ Staff initial _____ Date _____

Medical Information (continued)

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

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

Child's Insurance Provider

Child's health insurance provider	Policy number	Secondary health insurance provider	Policy number
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Child's Immunization History (please attach a copy of your child's immunization records)

Below is a list of immunizations that your child may have received. Immunizations starred in red are required by our state.

Anthrax	Influenza	*Pneumococcal disease	Smallpox
*Diphtheria	Lyme Disease	*Polio	*Tetanus
*Haemophilus Influenzae type b (Hib)	*Measles	Rabies	Tuberculosis
*Hepatitis A	Meningococcal disease	Rotavirus	Typhoid Fever
*Hepatitis B	*Mumps	*Rubella	*Varicella (Chickenpox)
Human Papillomavirus (HPV)	*Pertussis (Whooping Cough)	Shingles (Herpes Zoster)	Yellow Fever

Additional Medical Policies

1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations. **Initial**

2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs. _____
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious. _____
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release Authorization*. _____

Emergency Medical Authorization & Consent

- In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release Authorization*, and lastly my physician. **Initial**

- In case of a medical emergency, I agree that my child may receive first aid and/or CPR. _____
- In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary, by paramedics or other emergency personnel. _____
- In case of a medical emergency, I will be responsible for the emergency medical expenses. _____
- In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center. _____

Medical Administration

- I give my permission to this center to use baby wipes, diaper rash ointment, baby powder, Neosporin or similar ointments, bactine or similar first aid spray, band-aids, sunscreen and insect repellent on my child, which I have provided. **Initial**

- I understand that Kids Come First ELC does not administer prescription or over-the-counter medication to children, and children should remain home when sick. _____
- I have do not have special instructions for the application process. _____

Parent initial _____ Staff initial _____ Date _____

Parental Agreement and Contract

Child's name	Birth date
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Hours of Operation

Regular operating hours vary per location. For our Scenic Hwy location, operating hours are from **Monday – Friday, 6:30 AM – 7:00 PM**. For our Shannon Way location, operating hours are from **Monday – Friday, 6:00 AM – 6:30 PM**; except closings for various holidays and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures.

The procedure for notifying families should inclement weather or other conditions prevent the program from opening on time or at all will be announced on WSBTV, our website, by phone call and/or by text message. If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release Authorization*, and it will be your responsibility to arrange for your child's early pick up.

Scheduled Attendance

The days and hours that I wish to contract for childcare are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Select the meals your child will normally receive: Breakfast AM Snack Lunch PM Snack Supper

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

- Starting on _____ a fee of \$_____ is due weekly bi-weekly monthly. **Initial**
- Tuition is due and payable by: **8:30 AM** **Every Monday**, in advance of service. _____
- Tuition is **not** subject to discounts for holidays, emergency closures (i.e., weather, pandemic, power loss, etc.), or absence other than hospitalization, absence at the request of a doctor (**a written doctor's note is required to receive credit**), or 2 weeks' vacation during summer. _____
- **I agree to pay the full tuition plus 1-week deposit in advance of services rendered.** _____
- I agree to pay the full tuition fee even if my child is absent for one or more days. _____
- A late fee of **\$35** is due if tuition is not received on time. _____
- A non-refundable registration fee of **\$75** is due yearly. _____
- A late pick up fee of **\$1 per minute per child** (not to exceed \$25 per child) is due if my child is not picked up before closing. If my child is in care more than 15 minutes after closing, every attempt will be made to locate those listed in the *Child Emergency Contact and Release Authorization*. If contacts cannot be located within 1 hour, Child Protective Services may be contacted. _____
- Accounts two weeks in arrears may result in immediate termination of service. _____
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip may be required. _____
- All returned checks or ACH transactions (automatic debits) will be charged a fee of **\$35**. Two or more returned checks or ACH transactions will result in my account being placed on "**cash/money order only**" status. _____
- A **2-week written notice** is required for any child being withdrawn from the program. Failure to provide notice in writing will result in forfeiture of deposit. _____
- A receipt for income tax purposes will be provided. _____

Other Agreements

Private Employment Acknowledgement and Release

I acknowledge Kids Come First Early Learning Centers, Inc., does not condone and will not accept liability for care services provided by employees of Kids Come First ELC outside standard business hours or outside the childcare center premises. Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected to or sanctioned by this center. This center shall remain harmless from any such arrangement. **Initial**

Media Release

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

Parent initial _____ Staff initial _____ Date _____

Other Agreements (continued)

Child's name	Birth date
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Challenging Behavior Acknowledgement

<p>I acknowledge that if my child's behavior indicates that Kids Come First Early Learning Centers may not be able to meet his or her needs, the Director will contact me to arrange a meeting to be held within 24 hours. An action plan may be developed that establishes reasonable, attainable objectives for my child. If the site Director and/or Executive Director feel Kids Come First ELC cannot accommodate the needs of my child, or if the objectives established for my child are not met, Kids Come First ELC reserves the right to terminate my child's enrollment.</p>	Initial _____
<p>Additionally, I acknowledge Kids Come First ELC maintains a Zero Tolerance to bullying. Hitting, kicking, spitting, hostile verbal behavior and other behaviors which will hurt another child or staff member are not permitted, and is grounds for immediate termination of my child's enrollment. Any child who does not respect the physical boundaries at Kids Come First ELC, or exhibits behavior that threatens his or her wellbeing, or the wellbeing of others, after repeated attempts to correct the behavior, is subject to dismissal without notice.</p>	_____
<p>Any inappropriate behavior by a child/parent/guardian/authorized pickup person, including verbal or physical abuse of any child or staff member, or confrontations with any child or staff members, is grounds for immediate termination of the family's enrollment at Kids Come First ELC without notice.</p>	_____

Notice of No Liability Insurance

<p>I understand that I am being informed in writing by signing this acknowledgement that this facility, Kids Come First Early Learning Centers, Inc., does not carry liability insurance sufficient to protect my child(ren) in the event of an injury, etc.</p>	Initial _____
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Release Agreement

<p>I, for myself and my successors and assigns, as parents, legal guardians, or authorized custodians of my child, hereby release Kids Come First Early Learning Centers, Inc. (the childcare center) and each of its successors, affiliates, employees, and representatives from all claims, suits, losses, liabilities, and judgments of whatever kind arising from or related to or in connection with my child's enrollment with the childcare center including, without limitation, any loss or injury sustained by my child or myself as a result of my child's participation in activities sponsored or conducted by the childcare center and/or its employees, excluding only intentional torts performed by an employee of the childcare center during the time my child is in the care and custody of the childcare center.</p>	Initial _____
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Handbook Acknowledgement

<p>I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them. Childcare services may be denied in the event I do not comply with the terms of this Agreement, or when determined by Kids Come First ELC to be in the best interest of my child or the children using this Center.</p>	Initial _____
<p>I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.</p>	_____
<p>Information contained in the Family Handbook may be subject to change without notice.</p>	_____

Contract Approval

<p>I certify that I have read, understand, and accept all of the terms and conditions described in this <i>Enrollment Agreement</i>.</p>			
<p>_____ Primary Parent/Guardian/Sponsor Signature</p>	<p>_____ Date</p>	<p>_____ Center Staff Signature</p>	<p>_____ Date</p>

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 this center uses:

NORTHSIDE HOSPITAL GWINNETT
1000 MEDICAL CENTER BLVD.
LAWRENCEVILLE, GA 30046
(678) 312-1000



Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Kids Come First ELC 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 _____



Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **KIDS COME FIRST EARLY LEARNING CENTERS** 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.

KIDS COME FIRST ELC operates as an Institution of Affiliated Sites on the CACFP, in which all of our centers participate on the program. We will ensure that all our programs operate and comply with USDA standards. For more information about the CACFP, go to <http://www.fns.usda.gov/cacfp>.

Frequently Asked Questions

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 your center's main office.**
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 mark the appropriate section on the Income Eligibility Statement.

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 sponsoring organization.

In the operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex (including gender identity and sexual orientation), age, or disability. If you have other questions or need help, call **800-880-8849**.

Sincerely,



W. Essien Streater, Vice President/Program Contact, Kids Come First Early Learning Centers, Inc.

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
		<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 Income¹ - Sometimes children in the household earn or receive income. Please indicate the TOTAL Child Income/How often? (i.e., weekly, monthly, etc.)
 income received by child household members listed in PART I here. \$ _____/_____

B. Other Household Members¹. 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 along the frequency i.e., twice a month, weekly, etc. 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. Subsidies, 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 Part II B is completed and household members are listed (with or without income), 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: The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.

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

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

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: _____

INSTRUCTIONS

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. A Social Security Number is not necessary.

Part V: Answer this question if you choose to.

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 fields are blank, the person is certifying that there is no income to report. Please note that the last four digits of his or her Social Security Number is REQUIRED when/if **Part II B** is completed and household members are listed (with or without income).

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.

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

Sources of Income Chart¹

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	Please refer to the Income Eligibility Guidelines that are updated annually and available at https://www.decal.ga.gov/documents/attachments/IncomeEligibilityGuidelines.pdf
2	
3	
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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

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

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

1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
Program.Intake@usda.gov

This institution is an equal opportunity provider.

Sources of Income Chart¹

Sources of Income for Children		Sources of Income for Adults		
Sources of Child Income	Example(s)	Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages	- Salary, wages, cash bonuses	- Unemployment benefits	• Social Security (including railroad retirement and black lung benefits)
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits	- Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	• Private pensions or disability benefits • Regular income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household
-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			

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.

Definitions for Part 1 of the CACFP Meal Benefit Income Eligibility Statement

Foster Care	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.
Head Start Early Head Start *Proof required	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: <ul style="list-style-type: none"> ○ Approved Head Start application ○ Statement of Head Start enrollment ○ List of participants from a Head Start official
Migrant	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.
Runaway	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
Homeless	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: <ol style="list-style-type: none"> 1. Individuals who lack a fixed, regular, and adequate nighttime residence; and 2. Includes - <ol style="list-style-type: none"> 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.

Sharing Information with MEDICAID/SCHIP

Name of Child Care Center: Kids Come First Early Learning Centers

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 **the child care center office.**
(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 Statement 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, call the **main office** at 800-880-8849.

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.](#)

Good nutrition today means a stronger tomorrow!

Building for the Future

with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.



Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

Bright from the Start: Department of Early Care and Learning
Nutrition Services (Suite 754)
2 Martin Luther King, Jr. Dr., SE Atlanta, GA 30334
404-656-5987

www.dec.al.ga.gov

[Here is space for the sponsoring organization to add contact information]

Learn more about CACFP at USDA's website: <https://www.fns.usda.gov/>

USDA is an equal opportunity provider, employer, and lender.

United States Department of Agriculture

Food and Nutrition Service FNS-317

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