

Loving Care Learning Center Enrollment Form

Enrollment Date _____

Child's Name _____ Sex ____ Age ____ Birthdate _____

Home Address: Street _____ City _____ State _____

Zip Code _____ Cell Number _____

Father/Guardian Name _____ Contact Number _____

Address: Street _____ City _____ State _____ Zip Code _____

Place of Employment _____ Business Number _____

Employer's Street Address _____ City _____

State _____ Zip Code _____

Mother/Guardian Name _____ Contact Number _____

Address: Street _____ City _____ State _____ Zip Code _____

Place of employment _____ Business Number _____

Employer's Street Address _____ City _____

State _____ Zip Code _____

Child's Living Arrangements: () Both Parents () Mother () Father () other

Child's Legal Guardians: () Both Parents () Mother () Father () other

How you heard about Loving Care Learning Center: () Parent () Billboard () Parade () other

FAMILY REGISTRATION FORM

Emergency Contacts & Authorized Pickup Persons:

1st Contact/Pick Up Name _____ Home/Cell _____

Relationship to the Child: _____ Check all that apply: () Lives with () Emergency () Pickup

Address _____ City _____ State _____ Zip _____

2nd Contact/Pick Up Name _____ Home/Cell _____

Relationship to the Child: _____ Check all that apply: () Lives with () Emergency () Pickup

Address _____ City _____ State _____ Zip _____

3rd Contact/Pick Up Name _____ Home/Cell _____

Relationship to the Child _____ Check all that apply: () Lives with () Emergency () Pickup

Address _____ City _____ State _____ Zip _____

4th Contact/Pick Up Name _____ Home/Cell _____

Relationship to the Child: _____ Check all that apply: () Lives with () Emergency () Pickup

Address _____ City _____ State _____ Zip _____

Child's Physician, or Primary Health Source _____

Telephone Number _____

My child has the following need(s) _____

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: _____

PARENTAL AGREEMENT WITH CHILDCARE FACILITY

1. Loving Care Daycare Center agrees to provide day care for (Name child is called by) _____ on (Days of Week) _____.
_____ A.M. _____ P.M. from (month) _____ to (month) _____. My child will participate in the following meal plan (circle applicable meals and snacks):
Breakfast; lunch; afternoon snack.
2. My child will not be allowed to enter or leave the facility without being escorted by the parent/guardian, or person authorized by parents/guardian, or facility personnel.
3. 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 numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.
4. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.
5. Loving Care Daycare Center 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.
6. I have received a copy of the Operational Policy, Parent Handbook, and agree to abide by the policies for Loving Care Daycare Center.

If _____ suffers an injury or illness while in the care of Loving Care Daycare Center 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.

PARENTS/GUARDIANS _____ Date _____
Signature Signature

FACILITY ADMINISTRATOR/PERSON-IN-CHARGE

Signature _____ Date _____

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4. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.
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PARENTS/GUARDIANS _____ Date _____
Signature Signature

FACILITY ADMINISTRATOR/PERSON-IN-CHARGE

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

Original

Name of Sponsor (if applicable) _____

Name of Provider/Center Loving Care Daycare Center

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

I will provide Similac-Advanced and Gerber Rice Cereal to
Milk-based iron-fortified formula Iron fortified infant cereal

Infants enrolled for care in my facility.

Parents/Guardians, please check one of the following options and sign this form:

_____ I would like the provider/center to provide the milk-based iron-fortified infant formula and iron-fortified infant cereal listed above to my infant and I will provide clean, sanitized, and labeled bottles daily.

_____ I will provide _____ and
Milk-based Iron-fortified formula

_____ for my infant on a daily basis.
Iron-fortified cereal

Parent/Guardian Signature

Date

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

Georgia WIC Program

Georgia WIC
Georgia Department of Public Health
2 Peachtree Street, NW
10th Floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
Website: <http://dph.georgia.gov/WIC>

INCOME ELIGIBILITY GUIDELINES (Effective from July 1, 2016 to June 30, 2017)

Household size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	21,978	1,832	916	846	423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,874	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member add	+ 7,696	+ 642	+ 321	+ 296	+ 148

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.

Loving Care Learning Center

6040 Watson Blvd, Byron, GA 30088
478-953-8334

Dear Parent/Guardian:

Young children need healthy meals to learn. This letter is intended for parents or guardians of children enrolled at either a child care center or a family day care home. **Loving Care Learning Center** 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 of the CACFP by completing the attached Income Eligibility Statement 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. Below are answers to common questions about the Program:

1. **Do I need to fill out an IES form for each adult in day care?** Yes. Complete and submit one IES form for each child in your household that is enrolled in a day care center or family day care home. 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: **Loving Care Learning Center**. If your child (ren) is/are enrolled in a family day care home, please do not return this form to your family day care provider.
2. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, should on this application.
3. **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 center or day care home.
4. **Who should I include as members of household?** You must include all people in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you.
5. **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 you household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the family day care home or center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or proof of benefits as supported by a current Food Stamp, Temporary

Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards (participants with family members who become unemployed are eligible for the free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family income, during the period of unemployment, to be within the eligibility standards for those meals).

6. **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 but not if you only get it sometimes.
7. **What if I have foster children?** In certain cases foster children are eligible for free or reduced-price meals regardless of the income of such household with whom they reside.
8. **We are in the military. Do we include our housing allowance 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. All other allowances must be included in your gross income.

In the operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age, or disability.

If you have any questions or need help, call 478-953-8334.

Loving Care Learning Center

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
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income¹ - 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 Members¹ 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 _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

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

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

PART IV: Signature

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

Signature: X _____ Print Name: _____ Date: _____

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

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

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

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

Total income: _____ **Per:** ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ 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:** _____

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 Food Stamp, 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 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)	- Worker's compensation	- Private pensions or disability benefits
- Income from person outside the household	- A friend or extended family member regularly gives a child spending money	- Cash assistance from State or local government	- Supplemental Security Income (SSI)	- Regular income from trusts or estates
- Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust	- 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	- Cash assistance from State or local government	- Annuities
			- Alimony payments	- Investment income
			- Child support payments	- Earned interest
			- Veteran's benefits	- Rental income
			- Strike benefits	- Regular cash payments from outside household

Bright from the Start
Georgia Department of Early Care and Learning
Child and Adult Care Food Program

Income Eligibility Guidelines

(Effective from July 1, 2018 to June 30, 2019)

Household size	Free Meals					Reduced Price Meals				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	15,782	1,316	658	607	304	22,459	1,872	936	864	432
2	21,398	1,784	892	823	412	30,451	2,538	1,269	1,172	586
3	27,014	2,252	1,126	1,039	520	38,443	3,204	1,602	1,479	740
4	32,630	2,720	1,360	1,255	628	46,435	3,870	1,935	1,786	893
5	38,246	3,188	1,594	1,471	736	54,427	4,536	2,268	2,094	1,047
6	43,862	3,656	1,828	1,687	844	62,419	5,202	2,601	2,401	1,201
7	49,478	4,124	2,062	1,903	952	70,411	5,868	2,934	2,709	1,355
8	55,094	4,592	2,296	2,119	1,060	78,403	6,534	3,267	3,016	1,508
For each additional family member add	+5,616	+ 468	+ 234	+ 216	+ 108	+ 7,992	+ 666	+ 333	+ 308	+ 154

