ADMISSION INFORMATION

Operation Name	Director's Name	
First Baptist Church Child Development Center	Luella Dailey	
Child's Full Name	Child's Date of Birth	Child's Home Telephone No.
Child's Home Address		
Date of Admission / Date of Withdrawal		
Parent's or Guardian's Name	Address (if different from child's address)	

List telephone numbers below where parents/guardian may be reached while child will be in care:

Mother's Telephone No.	Father's Telephone No.	Guardian's Telephone No.	Cell Phone No

Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached: | Relationship

I hereby authorize the childcare operation to allow my child to leave the childcare operation **ONLY** with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

CHECK ALL THAT APPLY:

1. ☐ TRANSPORTATION: I hereby ☐ give ☐ do not give – consent for my child to be transported and supervised by the operation's employees:

Walk home ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. ☐ FIELD TRIPS: I hereby ☐ give ☐ do not give – my consent for my child to participate in Field Trips:

Parent's Comments:

3. ☐ WATER ACTIVITIES: I hereby ☐ give ☐ do not give – my consent for my child to participate in Water Activities:

☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play

4. ☐ RECEIPT OF WRITTEN OPERATIONAL POLICIES:

I acknowledge receipt of the facility's operational policies including those for discipline and guidance.

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

☐ **None** ☐ **Breakfast** ☐ **AM Snack** ☐ **Lunch** ☐ **PM Snack** ☐ **Supper** ☐ **Evening Snack**

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

☐ Mondays	from:	to:
☐ Tuesdays	from:	to:
☐ Wednesdays	from:	to:
☐ Thursdays	from:	to:
☐ Fridays	from:	to:
☐ Saturdays	from:	to:
☐ Sundays	from:	to:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____
Signature - Parent or Legal Guardian

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____
Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of sibling(s):

My child has permission to:
☐ walk to or from school or home,
☐ ride a bus, and/or
☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

_____ _____
Health Care Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

_____ _____
Signature - Parent or Legal Guardian Date

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____
Signature – Parent or Legal Guardian Date

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:	**Date of Birth**:

Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)	☐ Positive	☐ Negative	Date:

Signature or stamp of a physician or public health personnel verifying immunization information above. _____ _____

Signature or stamp of a physician or public health personnel verifying immunization information above. Signature Date

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

_____ _____

Parent's signature Date

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at
www.dshs.state.tx.us/immunize/public.shtm

_____ _____

Signature – Parent or Legal Guardian Date

First Baptist Church Child Development Center
Additional Information for Admission

CHILD: _____

FATHER: _____ Social Sec. No: _____

Employer: _____ Phone: _____

MOTHER: _____ Social Sec. No: _____

Employer: _____ Phone: _____

If parents are divorced, who has custody of child: Father _____ Mother _____ Other _____

List people who may pick up your child without prior notification (copy of their driver's license must be on file)

1. _____ Relationship _____ Phone_____

2. _____ Relationship _____ Phone_____

3. _____ Relationship _____ Phone_____

People who MAY NOT pick up your child. Please explain:

_____

_____

Church Affiliation: Mother _____ Father _____

Comments of any nature that will help the teacher help your child. (Examples: Allergies, fears, special needs, favorite activities, etc.)

_____

_____

Has your child been in child care before? ____ Where? _____

Siblings:
Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

_____
Signature Date

For Office Use Only: Copy of Mother's Driver's License in file. _____
Copy of Father's Driver's License in file. _____

From time to time, as part of our daily learning activities, we take still photos or video for use by the CDC only. We share these with you during special presentations such as our Parade of Stars program and graduation. Please complete and return the form below stating your preferences regarding your child.

****

The First Baptist Church Child Development Center _____ does _____ does not have my permission to include my child _____ when videotaping daily activities.

The First Baptist Church Child Development Center _____ does _____ does not have my permission to include my child _____ when photographing daily activities at FBC CDC, on field trips and the 4th of July Parade around the square.

The First Baptist Church Child Development Center _____ does _____ does not have my permission to use these pictures in various programs, in power points at our Thanksgiving Feast, Parade of Starts, Graduation, in the classroom, with art projects, and in some cases (in the local paper with my child's first and last name listed). We have a Church Website that they could possibly be placed on.

I understand this video/photography is for use only by the FBC CDC.

_____ _____

Parent/Guardian Signature Date

Enrollment Agreement

I am the parent/guardian of _____and I hereby make agreement to enroll my child in the FBC Child Development Center.

I have been informed of the CDC hours of operation, tuition, and registration and supply fee policies and understand registration fees are not refundable. I understand neither credit nor refund is granted for a child's absence from the center, CDC holidays or vacation. It is understood that the weekly tuition is due on the Friday proceeding the new week. If charges posted to your account are not paid by the proceeding Friday, a late charge of $5.00 per day will be posted to your account. Payments later than 3 days may result in termination of your child's place in the center. In case of withdrawal, tuition is payable to the end of the month in which the child is withdrawn unless a written notice of withdrawal is given two weeks in advance.

There will be a charge of $20.00 on all returned checks.

Parents failing to pick up their child by 6:00 PM will be charged a late fee of $10.00 and an additional $10.00 for every 15 minutes past 6:15. This will be due upon your arrival to the person left in charge of your child past 6:00 PM.

I understand I will be kept informed of persistent misconduct and will participate in the center's effort to remedy my child's misbehavior if needed. It shall be the policy of the FBC Child Development Center to use positive discipline and promote appropriate behavior through the use of rewards. Our goal is to promote the responsibility and interpersonal skills.

The state laws and procedures allowing the CDC to administer medication to my child have been reviewed and discussed with me and I understand I must follow these laws and procedures in order for the center to administer medications to my child.

I understand I may provide meals and/or snacks for my child instead of those prepared by the CDC. I understand if I do so, the CDC is not responsible for its nutritional value or for meeting the child's daily food needs.

I understand the FBC Child Development Center does not practice racial discrimination.

I have received and read the FBC Child Development Center Parent/Policy Handbook and I agree to comply with the policies and procedures outlined there along with the above mentioned policies. I understand that failure to accept these responsibilities could result in the CDC requesting that my child be removed from attendance.

_____ _____

Parent Signature Director/Assist. Director

Discipline and Guidance Policy for FBC CHILD DEVELOPMENT CENTER
Name of Operation

- Discipline must be:
  (1) Individualized and consistent for each child;
  (2) Appropriate to the child's level of understanding; and
  (3) Directed toward teaching the child acceptable behavior and self-control.

- A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  (3) Redirecting behavior using positive statements; and
  (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

- There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  (1) Corporal punishment or threats of corporal punishment;
  (2) Punishment associated with food, naps, or toilet training;
  (3) Pinching, shaking, or biting a child;
  (4) Hitting a child with a hand or instrument;
  (5) Putting anything in or on a child's mouth;
  (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  (7) Subjecting a child to harsh, abusive, or profane language;
  (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed; and
  (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and Guidance policy

_____ _____

Signature Date

Check one Please:

☐ Parent ☐ Employee/Caregiver ☐ Household member of child-care home

Child Assessment Form

Purpose:

These questions are designed to give you the information needed to provide the best, most appropriate care for children. This information is confidential and parents must be reassured it will not be shared without their written permission.

Experts in the field recommend completing an assessment form for each child. It can help start mutual trust and respect that will develop into a strong, cooperative partnership between parents and caregivers.

The assessment should be completed prior to enrollment. Give parents an opportunity to review your enrollment forms and parent handbook before you complete the assessment form. The parent handbook or operational policies set forth your program's philosophy and values.

The enrollment interview is the time to obtain critical information about the child and provide information on your program's operational policies, such as health checks (if conducted), procedures for the release of children, and illness and exclusion criteria. It also provides parents an opportunity to assess your program and determine if it is best suited for their child's needs.

Child Assessment Form

Child Name (last, first, middle)		**Social Security No.***	**Enrollment Date**	**Date of Birth**
Street Address (if rural, attach directions)		**City**	**County**	**Zip**
Mailing Address (if different) -- Street or P.O. Box		**City**	**County**	**Zip**
Telephone No. (include A/C)				

* If applicable.

1. Health

Does your child have any allergies?		☐ Yes	☐ No
If so, what allergies does your child have?			
How should we respond if he/she has an allergic reaction?			
Does your child have an existing illness?		☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?		☐ Yes	☐ No
Is your child taking any medication?		☐ Yes	☐ No
If so, how is the medication administered, and will it need to be administered while he/she is in care?			
Is the medication prescribed for continuous use?		☐ Yes	☐ No
Are there any side effects we should be alerted to?		☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?		☐ Yes	☐ No
How can we best help?			
What are your ideas about toilet training?			
How can we best help?			

3. Behavior:

Does your child have any special fears?		☐ Yes	☐ No
How does your child communicate his/her needs?		☐ Yes	☐ No
Are there any special words that your child uses that might not be readily recognized?			
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?			
When your child gets upset, what helps him/her calm down?			
What is a good way to distract your child when he/she is having a temper tantrum?			
Are there any particular routines that are particularly helpful at naptime?			

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	

4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?		☐ Yes	☐ No

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	

I verify that the above assessment was discussed with the parent(s) of _____

_____

_____

_____ _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

_____ _____

Signature of Parent Date Signed

Additional Comments:

Texas Dept. of Protective and Regulatory Services

AUTHORIZATION FOR EMERGENCY MEDICAL CARE
AUTORIZACION PARA ATENCION MEDICA DE EMERGENCIA

Form **2904**
November 1996

If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give my permission for:

Si en caso de alguna enfermedad o accidente no me pueden localizar para arreglar atención médica de emergencia para mi niño, doy permiso para que:

Name of Day Care Facility Owner or Director Nombre del Dueño o Director del Centro de Cuidado de Niños
Gwendolyn Dailey

to take my child (or children): a que lleve a mi niño (o mis niños):

Name of Child (1)/Nombre del Niño (1)	**Name of Child (2)**/Nombre del Niño (2)
Name of Child (3)/Nombre del Niño (3)	**Name of Child (4)**/Nombre del Niño (4)

to: a:

Name of Doctor/Nombre del Doctor	**Telephone No.**/Teléfono
Address of Doctor/Dirección del Doctor	

or to: o a:

Name of Hospital or Clinic/Nombre del Hospital o Clínica	**Telephone No.**/Teléfono
Address of Hospital or Clinic/Dirección del Hospital o Clínica	

I give consent for necessary emergency treatment when my child is in the care of this physician or hospital or clinic.

Doy mi consentimiento para el tratamiento médico necesario estando mi niño bajo la atención de este doctor u hospital o clínica.

_____ _____

Signature-Parent or Legal Guardian
Firma-Padre o Tutor

Date/Fecha

Texas Dept of Family and Protective Services

AUTHORIZATION FOR DISPENSING MEDICATION

Form 7238
May 2005

PARENT'S AUTHORIZATION

Name of Child to Receive Medicine		Name of Medication
Prescribing Physician	Prescription No.	Expiration Date
Dosage	When to Give	Continue Medication Until (date)

NOTE: Medication must be in its original container and labeled with your child's name and the date medication is left at the facility. Medication can only be administered in amounts according to the label directions.

Signature-Parent or Guardian _____ Date _____

CAREGIVER'S RECORD OF ADMINISTERING MEDICATION

CHILD'S NAME	NAME OF MEDICATION	DATE GIVEN	TIME GIVEN	AMOUNT GIVEN	FULL NAME OF CAREGIVER OR EMPLOYEE

Disposition of Left-over Medication

☐ Returned to Child's Parent/Guardian ☐ Thrown Away Date:

FP Assistance
Feeding the Future

Food Program Enrollment Form

Center Name: _____ CODE: _____

Child's Name: _____ Date of Birth: _____

Admission date: _____ Withdrawal Date: _____

1. Circle the days that your child will <u>normally</u> attend the center:

Mon Tue Wed Thu Fri Sat Sun

2. Circle the meals <u>normally</u> served to your child in the center:

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

3. What hours will your child <u>normally</u> be in the center:

____:_____ to ____:_____

4. Participant's ethnic and racial identities (optional)

Ethnicity (choose one ethnic identity):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race: (choose one or more racial identities):

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ White
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American

_____ _____

Parent Signature Date of Signature

(_____) _____-_____

Day Time Phone Number

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children**.** Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have an eligibility number, skip this part.
Part 3: Applies only to parents/guardians of children in Tier II Day Care Homes. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660),* provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

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: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

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 the participant for free or reduced price meals. You must include the last four digits of the Social Security Number 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 Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant 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 the participant 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:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Community Agencies that Provide Assistance

Food: Upshur County Shares Food Pantry **903-241-4412**
Monday & Wednesday 8:30 – 11:30 AM
210 Buffalo Street, Gilmer, TX 75644

Electric: Upshur County Rural Electric **903-843-2536**

Utility Bills, Gas, Prescription, Food – Tri County Community Action:
Monday through Friday 9:00 AM – 3:30 PM
Call Beth for appointment **903-843-0604**
1561 State Hwy 271 North, Gilmer, TX

Clothes Closet First United Methodist Church:
Thursday & Saturday 9 AM until Noon **903-843-2610**
107 North Montgomery, Gilmer, TX 75644

Early Childhood Intervention: **1-888-504-2229** Ages: birth – 36 months

Tuition assistance in paying for your child care? CCS
East Texas Work Force Solutions – Child Care Services:
1-800-676-8283 or 903-526-1105

WIC – Supplement Nutrition for Women, Infants & Children **1-800-924-3678**

Adult Protective Services: **903-843-2610**

Women's Center of East Texas: **1-800-447-5555**
PO Box 347, Longview, TX 75606

DFPS Texas Department of Family and Protective Services:
324 Yapaco Street, Gilmer, TX 75644 **903-843-0591**

Gilmer Housing Authority: **903-843-2141**
110 Buffalo Street, Gilmer, TX

Ore City Ministry Alliance: **903-968-3434** **Speak to: WeDena**

Ore City: New Hope Baptist Church: **903-968-4114**

Ore City: First Baptist Church: **903-968-3272**

Area Agency on Aging: **903-218-6500 (1-800-442-8845)** (see attached info)
1501 Pentecost Road Kilgore, TX 75662

Do you need assistance in paying for your child care?

<u>If you are working, training and/or going to school you may be eligible.</u>

- Must be working or have a combination of school and employment that equals 25 hours per week.
- Must pay a portion of the cost of care based on the family gross monthly income.
- Must meet income guidelines.
- Must meet other program criteria.
- May be placed on a waiting list.

CCS Income Guidelines	
Family Size	Gross Monthly Income (Up To)
2	$3,004
3	$3,710
4	$4,417
5	$5,124
6	$5,830
7	$5,963

Counties served: Anderson, Camp, Cherokee, Gregg, Harrison, Henderson, Marion, Panola, Rains, Rusk, Smith, Upshur, Van Zandt, and Wood.

For more information please call Child Care Services at 800.676.8283

WIC --The Special Supplemental Nutrition Program for Women, Infants and Children

1. What is WIC?

WIC provides nutritious foods, nutrition education (including breastfeeding promotion and support), and referrals to health and other social services to participants at no charge. WIC serves low-income pregnant, postpartum and breastfeeding women, and infants and children up to age 5 who are at nutrition risk.

The Texas Department of State Health Services (DSHS) administers this Federal program in Texas, to pay for WIC foods, nutrition education, breastfeeding promotion and support, and administrative costs.

2. Who is eligible?

Pregnant women, women who are breastfeeding a baby under 1 year of age, women who have had a baby in the past six months, and parents, step-parents, guardians, and foster parents of infants and children under the age 5 can apply for their children. To be eligible on the basis of income, applicants' income must fall at or below 185% of the U.S. Poverty Income Guidelines (see below).

A person who participates or has family members who participate in certain other benefit programs, such as the Supplemental Nutrition Assistance Program, Medicaid, or Temporary Assistance for Needy Families, automatically meets the income eligibility requirement.

WIC INCOME GUIDELINES
The WIC income guidelines below are effective beginning
July 1, 2016

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	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

3. What is "nutrition risk?"

Two major types of nutrition risk are recognized for WIC eligibility:

- Medically-based risks such as a history of poor pregnancy outcome, underweight status, or iron-deficiency anemia, and
- Diet based risks, such as poor eating habits that can lead to poor nutritional and health status.

Nutrition risk is determined through an initial health and diet screening at the WIC clinic.

4. What are the Health Benefits of WIC?

Studies show that WIC plays an important role in improving birth outcomes and containing health-care costs. WIC has a positive impact on children's diets. WIC improves infant-feeding practices by actively promoting breastfeeding as the best method of feeding infants. WIC clients have improved rates of childhood immunizations and a regular source of health care.

- Improved infant-feeding practices
- Premature births reduced
- Fetal death rate reduced
- Low birthweight reduced
- Long-term medical expenses reduced
- Improved dietary intake
- Improved cognitive development
- Fewer premature births

5. How do I contact DSHS about WIC?

Call toll free at (800) 942-3678 or (800) WIC-FOR-U; or go online to http://www.dshs.state.tx.us.

AREA AGENCY ON AGING

The Area Agency on Aging of East Texas is designated by the Texas Department of Aging and Disability Services to coordinate services for persons in East Texas who are 60 or older, with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.

As our population ages, it is important to provide support services which enable our seniors to live according to their choice, independently and with dignity. With a new face accompanying this changing population, we are constantly looking for new and innovative ways to keep up with the fast-paced baby boomers. We encourage and support volunteer and community groups to get involved.

The Area Agency on Aging is a program of the East Texas Council of Governments serving Anderson, Camp, Cherokee, Greg, Harrison, Henderson, Marion, Panola, Rains, Rusk, Smith, **Upshur**, Van Zandt and Wood counties.

Nutrition – Home-delivered meals, congregate meals, and nutritional counseling.

Senior Centers – Places to go for nutrition services, employment services, and health screening, as well as a venue for social interaction and recreation.

In-Home Assistance – Support for homebound elderly who want to be as independent as possible, including housekeeping, domestic chores, personal care, and visitation.

Care Coordination – Arrangement and coordination of services for older people in the most efficient, economical way.

Transportation – Rides to essential destinations such as nutrition sites, senior centers, doctors' appointments, and grocery shopping.

Information, Referral, and Assistance – Help getting information about federal, state, or local services.

Benefits Counseling/Legal Assistance – Help provided by trained benefits counselors on public and private benefits. Referrals to other sources of advice on legal matters.

Nursing Home Ombudsmen – Trained and certified volunteer advocates, supervised by professionals, who visit nursing facilities and work with the residents, families, and facility employees to achieve the best possible care and quality of life.

The Area Agency on Aging can be reached at (903) 218-6500 or toll free at 1-800-442-8845. Our offices are located at 1501 Pentecost Road, Kilgore, Texas 75662