MyNana's Clubhouse
info@mynanasclubhouse.com
912-559-2559

Enrollment Form

Entrance Date _____ **Withdrawal Date** _____

Child's Name _____ Sex ____ Age _____ Date of birth _____

Home Address (Street) _____ City _____ State _____ Zip _____

Home Phone Number _____

Father's Name _____ Home Phone Number _____

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

Street _____ City _____ State _____ Zip_____

Father's Place of Employment_____ Work Phone _____

Employer's Street Address _____ City _____ State _____ Zip_____

Mother's Name _____ Home Phone Number _____

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

Street _____ City _____ State _____ Zip_____

Mother's Place of Employment_____ Work Phone _____

Employer's Street Address _____ City _____ State _____ Zip_____

Child's Living Arrangements: (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Child's Legal Guardian(s): (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other

The child may be released to the person(s) signing this agreement or to the following:

*Name _____ Address _____
(Street-City-State-Zip)

Telephone Number _____ Relationship to child_____

Relationship to Parent(s) or Guardian _____

Other identifying information (if any) _____

*Name _____ Address _____
(Street-City-State-Zip)

Telephone Number _____ Relationship to child_____

Relationship to Parent(s) or Guardian _____

Other identifying information (if any) _____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name:_____ Telephone Number: _____

Name:_____ Telephone Number: _____

Name:_____ Telephone Number: _____

Name of Public or Private School child attends, if any: _____

Child's Doctor or Clinic Name: _____

Doctor/Clinic Phone Number: _____

My child has the following special needs: _____

_____

_____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: _____

_____

_____

_____

_____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____

_____

_____

EMERGENCY MEDICAL AUTHORIZATION

Should _____ Date of birth _____
(child's name)
suffer an injury or illness while in the care of MyNana's Clubhouse
(Facility name)
and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: _____ Date: _____
(Signature)

Center Director: _____ Date: _____
(Signature)

Parents or Guardian's
Notice of No Liability Insurance and Acknowledgment

I understand that I am being informed in writing by signing this acknowledgment that this facility, MyNana's Clubhouse, does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

_____
Parent or Guardian Name (Print)

_____
Parent or Guardian Name (Print)

_____ _____
Parent or Guardian's Signature **Date**

_____ _____
Parent or Guardian's Signature **Date**

_____ _____
Center Director's Signature **Date**

Parental Agreement with Child Care Facility

MyNana's Clubhouse agrees to provide child care for _____
(Name of Facility) (Name of Child)

on _____ from _____ a.m. to _____ p.m. from Jan to Dec.
(Days of Week) (Month) (Month)

My child will participate in the following meal plan (check applicable meals and snacks):

- ☐ Breakfast
- ☐ Lunch
- ☐ Afternoon Snack
- ☐ Dinner
- ☐ Evening Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

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

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

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

MyNana's Clubhouse agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for MyNana's Clubhouse.

I understand that the center will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed:_____ Date: _____
(Parent/Guardian)

Signed:_____ Date: _____
(Center Director)

SAFE SLEEP POLICY

1. Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a timeframe that the instructions are to be followed.
2. Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards
3. No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.
4. No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.
5. Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for comfort of the sleeping infant
6. Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/ mats will be laundered daily or marked for individual use. If marked for individual use, sheets/ covers must be laundered weekly or more frequently if needed.
7. Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will be moved to a safety- approved crib for sleep.
8. Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.
9. Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.
10. Parents must sign a copy of the Safe Sleep Practices Policy upon enrollment.

Reviewed by: _____ Director/Owner

_____ Staff member

_____Other (parent, advisory committee, police, CPS)

Effective Date and Review Date:

This policy is effective June 9, 2019 and will be reviewed annually or as needed.

ILLNESS POLICY FOR CHILDREN

LIFE THREATENING SIGNS TO BE AWARE OF:

- child is unresponsive
- child is having difficulty breathing, is breathing quickly, has shallow breaths, or is grunting
- a temperature above 100.4 Fahrenheit (in a baby less than 3 months old)
- a purple or red rash that doesn't go away when you press it
- child is pale or blue
- child is unusually drowsy or floppy
- child won't drink, is not passing urine, or has less than half the usual number of wet nappies
- repeated vomiting
- a high-pitched, continuous cry
- the fontanelle (soft spot on the baby's head) is bulging
- child is having a seizure (fit)
- child is having a severe allergic reaction (anaphylaxis).

When the policy applies:
This policy is in effect at all times.

Communication plan for staff and parents:
Staff and volunteers will receive a written copy of this policy in their orientation packets before beginning work at the facility. All parents will receive a written copy of this policy in the parent handbook and a copy of this policy will be posted on the parent bulletin board in each classroom. Parents, staff, and volunteers will receive written notification of any updates.

References: American Academy of Pediatrics (2009) Managing Infectious Diseases in Child Care and Schools, a quick reference guide 2nd edition.

Reviewed by: _____ Director/Owner
_____ Staff member
_____Other (parent, advisory committee, police, CPS)

Effective Date and Review Date:
This policy is effective June 9, 2019 and will be reviewed annually or as needed.

Infant Affidavit

Name of Provider/Center: **MyNana's Clubhouse**

Name of Infant: _____

Infant Date of Birth: _____

Printed Name of Parent/Guardian: _____

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

Center/provider will provide the following milk-based iron-fortified formula: **Parent's Choice**
Center/provider will provide the following Iron-fortified infant cereal: **Gerber**
Center/provider will provide the following brand of infant foods: **Gerber, Beech Nut, Earth's Best Organics, Plum Organics, Happytot**

Parents/Guardians,

Please check one of the following options below and sign this form:

☐ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

☐ I will provide the following meal component to my infant and the center will provide all other meal components:

- ☐ Formula*
- ☐ Cereal
- ☐ Fruit
- ☐ Vegetable
- ☐ Meat/Fish/Poultry/Eggs/Beans/Peas
- ☐ Cheese/Cottage Cheese/Yogurt
- ☐ Bread/Crackers/Breakfast 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. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

Date _____

MyNana's Clubhouse

INFANT FEEDING PLAN

Child's Full Name _____ Date of Birth _____

Does the child take a bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (check all that apply)

Strained Foods	[ ]	Whole Milk	[ ]
Baby Foods	[ ]	Table Food	[ ]
Formula	[ ]	Other	[ ]

What type formula used, if applicable?_____
Amount and time of formula/breast milk to be given?_____ Date _____

UPDATED AMOUNTS OF FORMULA/BREAST MILK TO BE GIVEN			
DATE	TIME	AMOUNT	TYPE

Does the child take a pacifier? Yes [ ] No [ ] If yes, when? _____

INTRODUCTION OF SOLID FOODS

The introduction of age-appropriate solid foods should preferably occur at six months of age, but no sooner than four months. Has the parent discussed with the child's primary caregiver that the child has met appropriate developmental skills for the introduction of solid foods? Yes [ ] No [ ] Parent Initials: _____

The child has reached the following developmental skills:
Can hold his/her head steady? Yes [ ] No [ ]
Opens mouth/leans forward in anticipation of food offered? Yes [ ] No [ ]
Closes lips around a spoon? Yes [ ] No [ ]
Transfers food from front of the tongue to the back and swallows? Yes [ ] No [ ]

Instructions for the introduction of solid foods _____
_____

Food likes _____

Food dislikes _____

Allergies? (including any premixed formula)_____

UPDATED AMOUNTS/TYPE OF FOOD TO BE GIVEN		
TIME	AMOUNT	TYPE

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____
_____

PARENT'S SIGNATURE: _____ Date: _____

Photo Release Permission Slip

As a parent or guardian of this child, I hereby consent to the use of photographs/videotape taken during the course of the year for publicity, promotional and/or educational purposes (including publications, presentation or broadcast via social media, internet or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use, or for damages.

____ Yes, I give consent for MyNana's Clubhouse to photograph my child for center purposes and/or at center events.

___ No, I do not authorize MyNana's Clubhouse to photograph my child for any event.

Parent Signature: _____ Date: _____

Child's Name: _____

Dear Parent/Guardian:

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

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: MyNana's Clubhouse 1985 Lanes Bridge Rd. Jesup GA 31545 -- 912-559-2559.**

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 low cost meals if your household income is within the reduced price limits on the Federal Income Chart, 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 Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **Sierra Mitchell, 1985 Lanes Bridge Rd. Jesup GA 31545 or call 912-559-2559.**

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. ***(Pricing program only)*** **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your **MyNana's Clubhouse enrollment representative.**

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

If you have other questions or need help, call **912-559-2599.**

Sincerely,

Jazmin Williamson, MNCH Administrator
CACFP Program Contact

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to.* Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced-price meals.).

□ No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address:_____

For more information, you may call _____ at _____

CACFP Meal Benefit Income Eligibility Form Sharing Information with Medicaid/SCHIP.

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	**Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)**				
		Head Start	Foster Child	Migrant	Runaway	Homeless
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

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

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

Child Income/How often? (i.e., weekly, monthly, etc.)
$_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only 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**: _____

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/Incomeeligibguidelines.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 Chart[1]

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).

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - 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
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - 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	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	▪ Social Security (including railroad retirement and black lung 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

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.

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 Dept of Early Care and Learning
BRIGHT FROM THE START

Income Eligibility Guidelines

(Effective from July 1, 2023 to June 30, 2024)

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 …..	18,954	1,580	790	729	365	26,973	2,248	1,124	1,038	519
2 …..	25,636	2,137	1,069	986	493	36,482	3,041	1,521	1,404	702
3 …..	32,318	2,694	1,347	1,243	622	45,991	3,833	1,917	1,769	885
4 …..	39,000	3,250	1,625	1,500	750	55,500	4,625	2,313	2,135	1,068
5 …..	45,682	3,807	1,904	1,757	879	65,009	5,418	2,709	2,501	1,251
6 …..	52,364	4,364	2,182	2,014	1,007	74,518	6,210	3,105	2,867	1,434
7 …..	59,046	4,921	2,461	2,271	1,136	84,027	7,003	3,502	3,232	1,616
8 …..	65,728	5,478	2,739	2,528	1,264	93,536	7,795	3,898	3,598	1,799
For each additional family member add	+ 6,682	+ 557	+ 279	+ 257	+ 129	+ 9,509	+793	+ 397	+366	+ 183