TEXAS Health and Human Services

Form 2935
April 2023

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name: Learning Tree Day School - 1077706		Director's Name: Mr. Umang P. Shah	
Child's Full Name:		Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian *(if different from the child's)*:	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

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

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

Parent Email:

Mother:

Father:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance: ◯ Yes ◯ No If no, what type of assistance is needed: _____

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯ Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. 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 Signed**

School Age Children

My child attends the following school:	School Area Code and Phone No.:

My child has permission to *(check all that apply)*:

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

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

_____ _____
Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

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. *(Select **only one** option.)*

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

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

◯ 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.

◯ 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 submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	SHOT
	6 months (third dose)	RECORDS
	12–15 months (fourth dose)	ATTACHED
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

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.

Signature **Date Signed**

Additional Information Regarding Immunizations

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

TB Test (If required)

◯Positive ◯Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

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

Signature **Date Signed**

Parent Handbook Acknowledgment Page

Child's Name: _____

I have read the Learning Tree Day School Parent Handbook and agree to abide by the policies and procedures as outlined in the handbook. I further agree to communicate with the teachers, staff, and Director if I have questions, concerns, or need more information.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that Learning Tree Day School is not responsible for lost, stolen, or damaged Cell Phones, Tablets, Video Games, MP3 Players, or any other items of value. We encourage the student not to bring these items from home.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that two weeks' written notice is required if my child will not attend Learning Tree Day School. I acknowledge that if I do not give two weeks' written notice, I will be financially responsible for the tuition and Specialty fees.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that Learning Tree Day School reserves the right to modify or amend the policies at any time without prior notice.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that my child may be featured in Learning Tree Day School's social media content (including but not limited to photos, videos, and posts).

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

This form serves as an acknowledgment by the parent or legal guardian regarding the understanding and acceptance of the policies outlined in the Learning Tree Day School Parent Handbook, including the potential use of the child in the school's social media content. Please sign and date each section to indicate your acknowledgment and agreement.

LEARNING TREE DAY SCHOOL

FINANCIAL POLICIES AGREEMENT

Name of child: _____

Tuition for your child's care is:_____ per month/bi-monthly

TUITION MUST BE PAID WHETHER OR NOT YOUR CHILD ATTENDS

A late payment charge of $20 will be incurred if payment is not received after the fifth of the month.

Monthly Tuition Schedule:

Payment Obligation: Childcare fees are applicable whether or not your child attends daycare on the agreed-upon days/hours. There will be no substitution, exchange, or breaks in fees for days when your child is absent due to illness, vacation, or any other reason.

Billing Cycle: Daycare billing occurs twice per month on the 1st and 15th for enrolled schoolers.

Preschool Tuition: Tuition for preschool programs is payable weekly, bi-monthly, or monthly, as per the selected payment schedule at enrollment.

Insufficient Funds: In the event of a returned check due to insufficient funds, a $30.00 fee will be assessed.

No Refunds or Prorated Tuition: There will be no refunds or prorated tuition for absences, whether they are excused or unexcused.

Enrollment Termination: Enrollment is subject to termination if payment is not received by the tenth of the month. Tuition is not prorated if a child withdraws for any reason before the end of the month.

I understand the above written policies and agree to follow them:

_____

Parent Signature

_____

Date

TEXAS Health and Human Services

Form 1099
September 2023

Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards Sections 744.501(7), 746.501(a)(7), and 747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

Discipline and Guidance Policy

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) grabbing or pulling a child;
4) putting anything in or on a child's mouth;
5) humiliating, ridiculing, rejecting or yelling at a child;
6) subjecting a child to harsh, abusive or profane language;
7) placing a child in a locked or dark room, bathroom or closet;
8) placing a child in a restrictive device for time out;
9) withholding active play or keeping a child inside as a consequence for behavior, unless the child is exhibiting behavior during active play that requires a brief supervised separation or time out that is consistent with 746.2803(4)(D); and
10) requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures

(Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise or proficiency:

- ensure that the measures are considered commonly accepted teaching or training techniques;
- describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) the disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) what behaviors would warrant the use of these measures; and
  - (C) the maximum amount of time the measures would be imposed;
- inform parents that they have the right to ask for additional information; and
- ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code Section 261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date: _____

Signed by: _____

Role: ◯ Parent ◯ Caregiver or Employee ◯ Household Member (CH. 747 only)

Minimum Standards Related to Discipline

- Title 26, Chapter 746 Subchapter L: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y
- Title 26, Chapter 747 Subchapter L: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y
- Title 26, Chapter 744 Subchapter G: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

☐ **Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s) _____.**

Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.

For **ANY** of the following **SEVERE** SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE BODY SYSTEM**, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM A **SINGLE BODY SYSTEM** (E.G. SKIN, GI, ETC.), FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE DATE

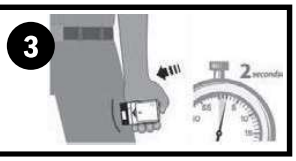
Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

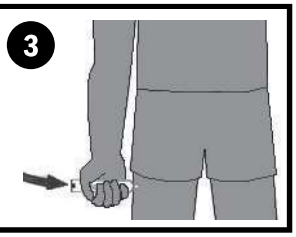
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q® from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q® against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



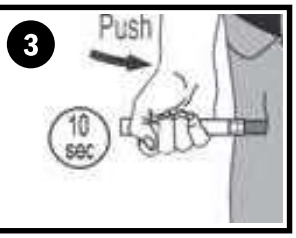
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



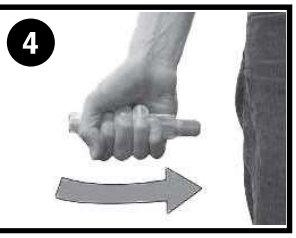
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Epinephrine first, then **call 911**. Monitor the patient and call their emergency contacts right away.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

TEXAS Health and Human Services

Form 2987
October 2023

Parent's Rights

This form provides the required information per Chapter 42 of the Human Resource Code (HRC) Section 42.04271.

Directions: Parents will review these rights upon enrolling their child.

Rights of Parent or Guardian

A parent or guardian of a child at a child care facility has the right to:

(1) enter and examine the child care facility during the facility's hours of operation without advanced notice;

(2) review the child care facility's publicly accessible records;

(3) receive inspection reports for the child care facility and information about how to access the facility's online compliance history;

(4) obtain a copy of the child care facility's policies and procedures;

(5) review, at the request of the parent or guardian, the facility's:

(A) staff training records; and

(B) any in-house staff training curriculum used by the facility;

(6) review the child care facility's written records concerning the parent's or guardian's child;

(7) inspect any video recordings of an alleged incident of abuse or neglect involving the parent's or guardian's child, provided that:

(A) video recordings of the alleged incident are available;

(B) the parent or guardian of the child does not retain any part of the video recording depicting a child that is not their own; and

(C) the parent or guardian of any other child captured in the video recording receives written notice from the facility before allowing a parent to inspect a recording;

(8) have the child care facility comply with a court order preventing another parent or guardian from visiting or removing the parent's or guardian's child;

(9) be provided the contact information for the child care facility's local Child Care Regulation office;

(10) file a complaint against the child care facility by contacting the local Child Care Regulation office; and

(11) be free from any retaliatory action by the child care facility for exercising any of the parent's or guardian's rights.

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signature of Parent or Guardian **Date**

Resources

Facility Information and Online Compliance History: http://txchildcaresearch.org

Child Care Regulation Contact Information: https://www.hhs.texas.gov/services/safety/child-care/contact-child-care-regulation

Family Orientation Checklist & Acknowledgment Form

Learning Tree Day School - Family Orientation

Welcome to our program! To ensure a smooth transition and provide essential information, we conduct a Family Orientation Session. Please check each item after completion. Your participation is vital in understanding our program's policies, procedures, and resources.

Family Orientation Checklist:

1. ☐ **Tour of the Facility:**
    - Introduction to the premises, highlighting key areas and facilities.
2. ☐ **Introduction to Teaching Staff:**
    - Meet and greet with staff members, providing an overview of their roles.
3. ☐ **Visit with Classroom Teacher:**
    - Opportunity to connect with the child's classroom teacher.
4. ☐ **Overview of Parent Handbook:**
    - Distribution and discussion of the Parent Handbook's key policies and guidelines.
5. ☐ **Policy for Arrival & Late Arrival:**
    - Explanation of arrival procedures and importance of punctuality.
6. ☐ **Consistent Arrival Time:**
    - Emphasize the significance of regular and consistent arrival times for the child's routine.
7. ☐ **Explanation of Texas Rising Star Quality Certification:**
    - Information regarding the center's certification and its significance in maintaining quality standards.
8. ☐ **Child Development & Developmental Milestones:**
    - Provide insights into child development stages and milestones.
9. ☐ **Encouragement for Information Sharing:**
    - Encourage parents to communicate any specific needs related to CCS enrollment.
10. ☐ **Overview of Family Support Resources:**
    - Information on available community resources and support activities for families.
11. ☐ **Technology Use Policy:**
    - Explain the center's policy on limited technology use to enhance communication.
12. ☐ **Statement on Family Role and Influence:**
    - Emphasize the vital role of families in a child's educational journey.
13. ☐ **Extended Classroom Visit Opportunity:**
    - Offer an extended visit for both parent and child to familiarize themselves with the classroom environment.

Acknowledgment:

I, _____ (Parent Name), have attended the Family Orientation Session at Learning Tree Day School. I confirm that I have received an overview of the program, policies, and resources as outlined in the Family Orientation Checklist above.

Parent Name: _____
Student Name: _____
Date: _____

Administrator Signature: _____
Date: _____

SITE NAME	
DIRECTOR	
DAYS OF OPERATION	
HOURS OF OPERATION	
MEALS SERVED	

SITE ADDRESS	
SITE PHONE	
SITE EMAIL	
IRON-FORTIFIED INFANT FORMULA PROVIDED BY SITE	

Medical-Special Dietary Needs Modification Statement

PARENTS: Carefully read and follow the procedures for requesting a special dietary need meal modification.
Incomplete Special Dietary Needs Forms will not be accepted.

When To Use This Form:

- A special dietary need that allows a substitute food component from same food group.....**Complete Parts A, B & C**
  (example: child has an intolerance for strawberries and a different fruit can be substituted)
- A medical statement that prohibits the serving of specific food component and lists appropriate substitutions.....**Complete Part D**
  (this form can be used in lieu of a Clinic's medical statement as long as a medical authority signs the form

How To Complete This Form:

Part A - Form must be completed by the Parent/Guardian
Part B - Form must be completed by the Parent/Guardian
Part C - Form must be signed and dated by the Parent/Guardian
Part D - Form must be signed by the licensed Medical Authority

Part A. Student and Parent/Guardian Information – To be completed by a parent/guardian

Student's Name:	Date of Birth: _____/_____/_____
Parent/Guardian's Name:	Parent/Guardian's Phone: (_____) _____-_____
Name of Site/Center:	Site/Center Location (city):

☐ **Part B. Special Dietary Need (not requiring a Doctor's Statement)**

List specific food items the child cannot tolerate and parent wishes to substitute with a different item (within same food group):

	Center Provided	Parent Provided
☐ **Whole Milk:** Replaced With _____ (Brand Name) Unflavored Lactose Free/Reduced Whole Milk (1 yr olds only)	☐	☐
☐ **Whole Milk:** Replaced With _____ (Brand Name) Unflavored Soy Milk (1 yr olds only)	☐	☐
☐ **1% Milk:** Replaced With _____ (Brand Name) Unflavored Lactose Free/Reduced 1% Milk (2 -5 yr olds only)	☐	☐
☐ **1% Milk:** Replaced With _____ (Brand Name) Unflavored Soy Milk (2 - 5 yr olds only)	☐	☐
☐ **1% Milk:** Replaced With _____ (Brand Name) [ ] Unflavored [ ] Flavored Lactose Free/Reduced 1% Milk (6 -18 yr olds only)	☐	☐
☐ **1% Milk:** Replaced With _____ (Brand Name) [ ] Unflavored [ ] Flavored Soy Milk (6 -18 yr olds only)	☐	☐
☐ _____ (Scheduled Component) Replaced With _____ (Substituted Component)	☐	☐
☐ _____ (Scheduled Component) Replaced With _____ (Substituted Component)	☐	☐
☐ _____ (Scheduled Component) Replaced With _____ (Substituted Component)	☐	☐
☐ _____ (Scheduled Component) Replaced With _____ (Substituted Component)	☐	☐

☐ **Part C. Parent/Legal Guardian Permission –** *To be completed by a parent or legal guardian.*

I certify that all information listed above is true & factual and I give permission for Site/Center personnel responsible for providing my child's diet to discuss my child's special dietary accommodations with the Site/Center's CACFP Sponsor.

Parent/Legal Guardian's Signature_____ Date of Signature: _____/_____/_____

☐ **Part D. Alternate Medical Statement by Medical Authority (This form can be used in lieu of a Clinic's own Medical Statement)**

List specific food items the child cannot tolerate and what food items the child is allowed to have as a replacement.

Omit The Following Food Components due to a Medical Condition	Substitute Omitted Food Components with these Food Components

Medical Authority's Signature_____ Date of Signature: ____/_____/_____

CACFP STUDENT ENROLLMENT FORM

CM-1500

Center Name

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals / snacks for your children. Federal CACFP regulations require all parents/guardians to complete a CACFP Enrollment Form when enrolling their child(ren) and review/update enrollment data annually thereafter.

CHILD INFORMATION

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: __/__/__
Re-Enroll Date __/__/__

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: __/__/__
Re-Enroll Date __/__/__

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: __/__/__
Re-Enroll Date __/__/__

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature _____ **Date** _____

Parent First Name

Parent Last Name

Cell Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

This institution is an equal opportunity provider.

SITE / SPONSOR USE ONLY

Center Name

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Names of all household members (First, Middle Initial, Last)	CHECK IF ENROLLED CHILD	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 4.**

NAME: ______________________ ELIGIBILITY NUMBER: _ _ _ _ _ _ _ _ _

*SNAP or TANF number must be the 8 or 9 digit **EDG#** assigned by HHSC.

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	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	2. Welfare, child support, alimony	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	3. Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	4. All Other Income	Weekly	Every 2 Weeks	2x Month	Monthly	Annually
Example: JJane Smith	$ 200	☑	☐	☐	☐	☐	$ 150	☐	☐	☑	☐	☐	$ 100	☐	☐	☐	☑	☐	$ 100	☐	☐	☑	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐
	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐	$____	☐	☐	☐	☐	☐

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, 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/ad-3027.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;

(2) fax: (833) 256-1665 or (202) 690-7442;

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Infant Declaration Form:

Center Name

INSTRUCTIONS TO PARENTS:

Complete BOTH sections on this form. Sign and date where indicated. Submit to child care provider.

Section 1

Infant's Name _____ Birth Date: ____ / ____ / ____

Parent's Name _____

My child is allergic to the following foods:
(A Doctor's note is required for any foods that cannot be substituted within the same food group.)

_____ _____

Section 2

Your child care provider offers the following iron-fortified infant formula(s): _____

Parent Declaration - ***Select only ONE of the following options.***

☐ **CENTER will provide ALL meal components for infant named above.**

or

☐ **PARENT will provide ALL meal components for infant named above.**

or

☐ **BOTH PARENT and CENTER will provide meal components for infant named above, as indicated below.**

		0-5 Months	6-11 Months
○ *Center* or ○ *Parent*	*will provide Iron Fortified Infant Formula / Breast Milk* ○ (Infant Formula Brand Name: _____)	☐	☐
○ *Center* or ○ *Parent*	*will provide Iron Fortified Infant Cereal*		☐
○ *Center* or ○ *Parent*	*will provide Infant Fruits/Vegetables*		☐
○ *Center* or ○ *Parent*	*will provide Infant Meats*		☐
○ *Center* or ○ *Parent*	*will provide Crusty Bread/Crackers*		☐

***** This form must be updated and submitted any time there is a change in Section 2.**

I understand that once my infant child turns 6 months of age, it is my responsibility to notify the child care center director as to any limitations of solid foods that my infant child is not developmentally ready to receive.

_____ (_____)_____-_____ _____ / _____ / _____

Parent Signature **Parent Phone Number** **Date**

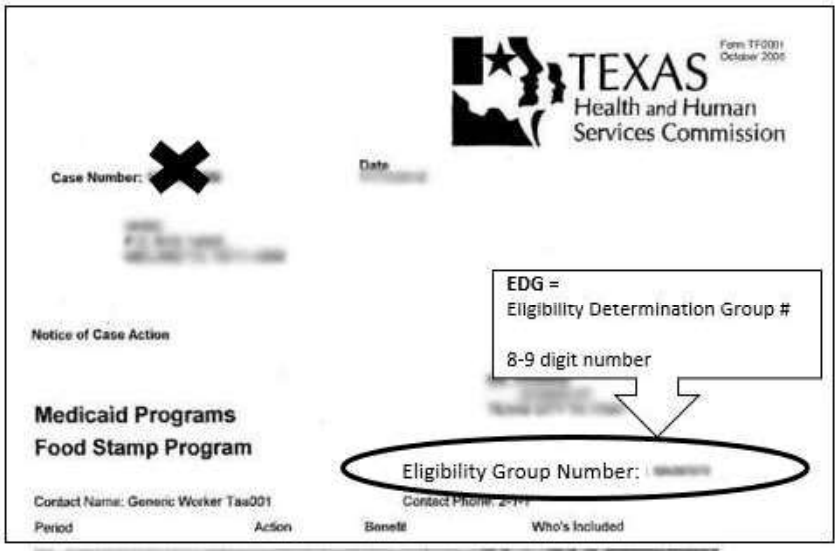
**Please include your phone number so our CACFP Sponsor can contact you if they have any questions.*

For Sponsor Use Only

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 (see illustration).
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. See next.

This letter is intended for the parents or guardians of children enrolled at:

Dear Parent/Guardian:

This child care 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 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 the child care center's director.**

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) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Income Chart, sent with this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May 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 can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

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

10. ***(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 can speak to Amy Pringle by telephone at (832) 282-1351. You may ask for a hearing by calling or writing to Max Taylor, Advance Child Care, Inc.; 523 West First Ave; Corsicana, Texas 75110, (903)872-5231.

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 Amy Pringle at (832) 282-1351.

Sincerely,

Texas Department of Agriculture
Form 1625-A
February, 2023

Income Eligibility Guidelines for Determining Free or Reduced-Price Benefits July 1, 2023 - June 30, 2024

Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.

Ingresos máximos para determiner la elegibilidad para beneficios gratuitos o a precio reducido 1 de julio de 2023 - 30 de junio de 2024

Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	$26,973	$2,248	$1,124	$1,038	$519
2	$36,482	$3,041	$1,521	$1,404	$702
3	$45,991	$3,833	$1,917	$1,769	$885
4	$55,500	$4,625	$2,313	$2,135	$1,068
5	$65,009	$5,418	$2,709	$2,501	$1,251
6	$74,518	$6,210	$3,105	$2,867	$1,434
7	$84,027	$7,003	$3,502	$3,232	$1,616
8	$93,536	$7,795	$3,898	$3,598	$1,799
For each additional family member add:	$9,509	$793	$397	$366	$183

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 for 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.

Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program.

Questions? Concerns?

Call USDA at
1-866-873-2263

OR

Food and Nutrition Division at
1-800-TELL-TDA
(835-5832)

ADVANCE Child Care, Inc.
(903) 872-5231
cacfpinfo@advcc.org

TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER
Fraud Hotline: 1-866-5-FRAUD-4 or 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711
Toll Free: (877) TEX-MEAL | For the hearing impaired: (800) 735-2989 (TTY)

square meals
Food and Nutrition Division
Child and Adult Care Food Program

This product was funded by USDA.
This institution is an equal opportunity provider.

Updated 11/17/2021
www.SquareMeals.org

Join Texas WIC

We're here for you

"Thanks to WIC, I now have the tools I need to make sure my family stays on the path to a healthy lifestyle."

—Roxie, WIC Client

As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	$ 3,152	$ 37,814
3	$ 3,981	$ 47,767
4	$ 4,810	$ 57,720
5	$ 5,640	$ 67,673
6	$ 6,469	$ 77,626

Effective April 1, 2024

* A pregnant woman's household is increased by the number of infants she is expecting. If you have any income questions, call 1-800-942-3678.

Start now. Call 1-800-942-3678 or visit TexasWIC.org

TEXAS Health and Human Services | TEXAS WIC

This institution is an equal opportunity provider.

 Stock no. 13-06-15123 Rev. 4/24

FORMULARIO DE INSCRIPCIÓN DE ESTUDIANTES CACFP

CM-1500

Nombre del centro

Esta institución participa en el Programa de Alimentos para el Cuidado de Niños y Adultos (CACFP) y recibe reembolso para proporcionar comidas / meriendas más nutritivas para sus hijos. Las regulaciones federales de CACFP requieren que todos los padres/tutores completen un Formulario de inscripción de CACFP cuando inscriban a sus hijos y revisen/actualicen los datos de inscripción anualmente a partir de entonces.

INFORMACIÓN DE NIÑOS

Fecha de Inscripción Primer ☐☐ / ☐☐ / ☐☐☐☐

Nombre del Niño(a)

Apellido del Niño(a)

Fecha de Nacimiento ☐☐ / ☐☐ / ☐☐☐☐

Días Normales en Cuidado L M M J V S D

Horas Normales de Cuidado ☐ AM ☐ PM to ☐ AM ☐ PM

Comidas/Meriendas Que el Niño(a) Recibe DES | MER AM | ALM | MER PM | CENA | MER NOCHE

Identidad Étnica (Marque uno)
- ☐ Hispano(a) o Latino
- ☐ No Hispano(a) o Latino

Identidad Racial (Marque todo lo que corresponda)
- ☐ Blanca
- ☐ Negra/Afroamericana
- ☐ India Americana/Alaska
- ☐ Asiática
- ☐ Hawaiano Nativo/Otra Isleño del Pacífico

Gender
- ☐ Femenino
- ☐ Masculino

USO EXCLUSIVO DEL SITIO/PATROCINADOR

Fecha de Retiro: __/__/____

Fecha de Reinscripción: __/__/____

Fecha de Inscripción ☐☐ / ☐☐ / ☐☐☐☐

Primer Nombre del Niño(a)

Apellido del Niño(a)

Fecha de Nacimiento ☐☐ / ☐☐ / ☐☐☐☐

Días Normales en Cuidado L M M J V S D

Horas Normales de Cuidado ☐ AM ☐ PM to ☐ AM ☐ PM

Comidas/Meriendas Que el Niño(a) Recibe DES | MER AM | ALM | MER PM | CENA | MER NOCHE

Identidad Étnica (Marque uno)
- ☐ Hispano(a) o Latino
- ☐ No Hispano(a) o Latino

Identidad Racial (Marque todo lo que corresponda)
- ☐ Blanca
- ☐ Negra/Afroamericana
- ☐ India Americana/Alaska
- ☐ Asiática
- ☐ Hawaiano Nativo/Otra Isleño del Pacífico

Género
- ☐ Femenino
- ☐ Masculino

USO EXCLUSIVO DEL SITIO/PATROCINADOR

Fecha de Retiro: __/__/____

Fecha de Reinscripción: __/__/____

Fecha de Inscripción ☐☐ / ☐☐ / ☐☐☐☐

Primer Nombre del Niño(a)

Apellido del Niño(a)

Fecha de Nacimiento ☐☐ / ☐☐ / ☐☐☐☐

Días Normales en Cuidado L M M J V S D

Horas Normales de Cuidado ☐ AM ☐ PM to ☐ AM ☐ PM

Comidas/Meriendas Que el Niño(a) Recibe DES | MER AM | ALM | MER PM | CENA | MER NOCHE

Identidad Étnica (Marque uno)
- ☐ Hispano(a) o Latino
- ☐ No Hispano(a) o Latino

Identidad Racial (Marque todo lo que corresponda)
- ☐ Blanca
- ☐ Negra/Afroamericana
- ☐ India Americana/Alaska
- ☐ Asiática
- ☐ Hawaiano Nativo/Otra Isleño del Pacífico

Género
- ☐ Femenino
- ☐ Masculino

USO EXCLUSIVO DEL SITIO/PATROCINADOR

Fecha de Retiro: __/__/____

Fecha de Reinscripción: __/__/____

INFORMACIÓN DEL PADRE/TUTOR

Certifico que la información en este formulario es verdadera y correcta a lo mejor de mi conocimiento y que he recivido acceso a la literatura de WIC y CACFP en los últimos 12 meses.

_____ **Signature**

_____ **Date**

Nombre del Padre

Apellido del Padre

Teléfono Celular ☐☐☐ - ☐☐☐ - ☐☐☐☐

Esta institución es un proveedor que ofrece igualdad de oportunidades.

USO EXCLUSIVO DEL SITIO/PATROCINADOR

Formulario de Declaración Infantil:

Nombre del centro

INSTRUCCIONES A LOS PADRES:

Complete AMBAS secciones de este formulario. Firma y fecha donde se indica. Entregue al proveedor de cuidado infantil.

Sección 1

Nombre del Infante _____ Fecha de Nacimiento ____ / ____ / ____

Nombre de los Padres _____

Mi hija(o) es alérgica(o) a los siguientes alimentos:
(Se requiere una nota del médico para cualquier alimento que no se pueda sustituir dentro del mismo grupo de alimentos.)

_____ _____

Sección 2

Su proveedor de cuidado infantil ofrece las siguientes fórmulas infantiles fortificadas con hierro:

_____

Declaración de los padres - ***Seleccione solo UNA de las siguientes opciones.***

☐ **EL CENTRO proporcionará TODOS los componentes de la comida para el infante mencionado anteriormente.**

O

☐ **LOS PADRES proporcionán TODOS los componentes de la comida para el infante mencionado anteriormente.**

O

☐ **TANTO LOS PADRES COMO EL CENTRO proporcionarán los componentes de la comida para el infante mencionado anteriormente, como se indica a continuación:**

		0-5 Meses	6-11 Meses
◯ ***Centro*** o ◯ ***Los Padres***	*proporcionará(n) fórmula infantil fortificada con hierro / leche materna* ◯	☐	☐
	Marca de fórmula infantil		
◯ ***Centro*** o ◯ ***Los Padres***	*proporcionará(n) cereal infantil fortificado con hierro*		☐
◯ ***Centro*** o ◯ ***Los Padres***	*proporcionará(n) frutas/verduras para el infante*		☐
◯ ***Centro*** o ◯ ***Los Padres***	*proporcionará(n) carnes para el infante*		☐
◯ ***Centro*** o ◯ ***Los Padres***	*proporcionará(n) pan/galletas crujientes*		☐

***Esté formulario debe ser actualizado y entregado al centro cada vez que haya un cambio en la sección 2.**

Entiendo que una vez que mi hijo pequeño cumpla 6 meses de edad, es mi responsabilidad notificar al director del centro de cuidado infantil sobre cualquier limitación de alimentos sólidos que mi hijo pequeño no este listo para recibir desde el punto de vista del desarrollo.

_____ (_____)_____-_____ _____ / _____ / _____

Firma del Padre/Madre **Número de teléfono de los padres** **Fecha**

**Por favor incluya su número de teléfono para que nuestro patrocinador de CACFP pueda comunicarse con usted si tiene alguna pregunta.*

Solo Para Uso Del Patrocinador

Esta institución es un proveedor que ofrece igualdad de oportunidades.

Esta carta está destinada a los padres o tutores de los niños matriculados en

Estimado Padre/Tutor:

Este centro de cuidado infantil ofrece comidas saludables para todos los niños inscritos como parte de nuestra participación en el Programa de Atención Alimenticia para Niños y Adultos (CACFP, por sus siglas en inglés) del Departamento de Agricultura de Estados Unidos (USDA, por sus siglas en inglés). El CACFP ofrece reembolsos por comidas y meriendas saludables que se les sirven a los niños inscritos en centros de cuidado de niños. Por favor, ayúdenos a cumplir con los requisitos del CACFP llenando el Formulario de Calificación por Ingresos para el Beneficio de Comidas que está adjunto a esta carta. Además, al llenar este formulario, podremos determinar si su hijo(s) califica para recibir comidas gratis o a un precio reducido.

1. ¿Debo llenar un Formulario de Calificación para el Beneficio de Comidas por cada hijo que esté en un centro de cuidado diario? Podría ser que tenga que completar y presentar un Formulario de Calificación por Ingresos para el Beneficio de Comidas del CACFP para todos los niños de su hogar que están inscritos para recibir cuidado diario, pero sólo si están inscritos en el mismo centro. No podemos aprobar un formulario que no esté completo, por eso, debe asegurarse de leer las instrucciones con cuidado y llenar toda la información que se solicita. Devuelva el formulario ya llenado a centros de cuidado infantile.

2. ¿Quién puede recibir comidas gratis sin tener que entregar información sobre ingresos? Pueden recibir comidas gratis los niños en hogares inscritos en el Programa de Asistencia de Nutrición Suplementaria (SNAP) (anteriormente "Estampillas para comida"), Asistencia Temporal para Familias Necesitadas (TANF), o el Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR). Los niños en familias de crianza (consulte la pregunta Nº 8 si desea más información sobre niños de crianza) y los niños inscritos en el Programa "Head Start" (HSP), el Programa "Early Head Start" (EHSP), o el Programa Even Start ESP) y que aún no han comenzado el jardín infantil, también califican para recibir comidas gratis. Los hogares que tienen niños inscritos en un HSP, EHSP, o ESP, pueden entregar una carta de certificación del programa de que el niño está inscrito, y así no necesitan llenar un Formulario de Calificación por Ingresos para el Beneficio de Comidas del CACFP.

3. ¿Quién puede recibir comidas a precios reducidos? Los niños pueden recibir comidas a precios reducidos si los ingresos de su hogar están dentro de los límites de precios reducidos de la Tabla de Ingresos que se envió junto con esta solicitud. Los niños en hogares que participan en WIC podrían calificar para recibir comidas a precio reducido.

4. ¿Puedo llenar el formulario si en mi hogar hay una persona que no es ciudadano estadounidense? Sí. Ni usted ni sus hijos tienen que ser ciudadanos estadounidenses para calificar para el beneficio de comidas del centro.

5. ¿A quiénes debería incluir como miembros de mi hogar? Debe incluir a todos los miembros de su hogar (es decir, los abuelos, otros parientes, o amigos que viven con usted) que comparten los ingresos y los gastos. Debe incluirse usted mismo y a todos los niños que viven con usted. También puede incluir a los niños de crianza que viven con usted.

6. ¿Cómo entrego la información sobre mis ingresos y notifico los cambios en mi situación laboral? Su informe de ingresos debe presentar los ingresos totales brutos recibidos el último mes por cada miembro del hogar indicando la fuente. Si su informe de ingresos del último mes no refleja con exactitud su situación, puede presentar una proyección de sus ingresos mensuales. Si no ha tenido cambios importantes, puede usar los ingresos del mes pasado como base para preparar esa proyección. Si los ingresos de su hogar son iguales o inferiores a los montos indicados para el tamaño de su hogar en la Tabla de Ingresos adjunta, el centro recibirá un mayor nivel de reembolsos. Una vez que tenga la aprobación para recibir beneficios gratis o a precios reducidos, ya sea mediante ingresos o presentando un número de caso vigente del SNAP, TANF, o FDPIR, usted seguirá calificando para recibir esos beneficios por 12 meses. Sin embargo, deberá notificarnos si usted o alguien de su hogar queda desempleado y la pérdida de ingresos hace que los ingresos de su hogar queden dentro de los parámetros para calificar.

7. ¿Qué puedo hacer si mis ingresos no siempre son iguales? Indique el monto que percibe normalmente. Por ejemplo, si sus ingresos mensuales generalmente son de $1000, pero en el último mes no trabajó tanto y sólo recibió $900, indique que recibe $1000 mensuales. Si generalmente trabaja horas extras, debe incluir eso también, pero no lo incluya si es solamente a veces.

8. ¿Qué hago si tengo niños de crianza? Los niños de crianza que están bajo la responsabilidad legal de una agencia o un tribunal de crianza califican para recibir comidas gratis. Cualquier niño de crianza del hogar califica para recibir comidas gratis independientemente de los ingresos del hogar. Los hogares pueden incluir a niños de crianza en el Formulario de Beneficios de Comidas, pero no están obligados a incluir los pagos recibidos para el niño de crianza como ingresos. Los hogares que deseen solicitar esos beneficios para los niños de crianza pueden entregar al cuidador del niño el Formulario 2085FC *Autorización de Colocación en Crianza / Cuidado Residencial* del Departamento de Servicios para la Familia y de Protección de Texas, y así no tendrán que llenar el Formulario de Calificación por Ingresos para el Beneficio de Comidas del CACFP.

9. Pertenecemos al ejército, ¿debemos incluir nuestras pensiones de vivienda y suplementaria como ingresos? Si su vivienda forma parte de la Iniciativa de Privatización de Viviendas del Ejército, y además recibe Un Beneficio Suplementario de Subsistencia Familiar, no incluya esas pensiones como ingresos. Además, con relación a miembros del ejército en zonas de combate, sólo se contará como ingresos del hogar la parte de los ingresos del miembro del ejército que hayan sido designados por él o a nombre suyo para que vayan al hogar. Los sueldos por combate, incluyendo el Pago de Incentivos de Extensión de Servicio (DEIP) también quedan excluidos y no se contarán como ingresos del hogar. Todas las demás pensiones se deben incluir en sus ingresos brutos.

10. ***(Únicamente para el programa de precios) ¿Se verificará la información que yo presente?*** Quizás. Quizás le pidamos que envíe prueba escrita para verificar la información que presentó en el formulario. **¿Qué pasa si no estoy de acuerdo con la decisión que se tome sobre la información que yo coloque en este formulario?** Puede hablar con Amy Pringle por teléfono al (832) 282-1351. Puede solicitar una audiencia llamando o escribiendo a: Max Taylor, Advance Child Care, Inc.; 523 West First Ave; Corsicana, Texas 75110, (903)872-5231.

En el manejo de los programas de alimentación infantil, no se discriminará a personas según su raza, color de la piel, nacionalidad de origen, género, edad, o discapacidad.

Si tiene alguna otra pregunta, o necesita ayuda, llame Amy Pringle al (832) 282-1351.

Atentamente,

Texas Department of Agriculture!
Form 1625-A
March, 2024

Income Eligibility Guidelines for Determining Free or Reduced-Price Benefits July 1, 2024 - June 30, 2025

Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.

Ingresos máximos para determiner la elegibilidad para beneficios gratuitos o a precio reducido 1 de julio de 2024 - 30 de junio de 2025

Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	$27,861	$2,322	$1,161	$1,072	$536
2	$37,814	$3,152	$1,576	$1,455	$728
3	$47,767	$3,981	$1,991	$1,838	$919
4	$57,720	$4,810	$2,405	$2,220	$1,110
5	$67,673	$5,640	$2,820	$2,603	$1,302
6	$77,626	$6,469	$3,235	$2,986	$1,493
7	$87,579	$7,299	$3,650	$3,369	$1,685
8	$97,532	$8,128	$4,064	$3,752	$1,876
For each additional family member add:	$9,953	+$830	+$415	+$383	+$192

Nombre del centro

FORMULARIO DE CALIFICACIÓN POR INGRESOS PARA EL BENEFICIO DE COMIDAS DE CACFP (Cuidado para niños)

Parte 1. Todos los miembros del hogar

Nombre del niño(s) inscrito(s):

Nombre de todos los miembros del hogar (Nombre, inicial de segundo nombre, apellido)	MARQUE SI ES UN HIJO DE CRIANZA (RESPONSABILIDAD LEGAL DE UNA AGENCIA DE ASISTENCIA SOCIAL O TRIBUNAL) * SI TODOS LOS NIÑOS QUE APARECEN ABAJO SON HIJOS DE CRIANZA, SÁLTESE A LA PARTE 5 Y FIRME ESTE FORMULARIO.	MARQUE SI NO HAY INGRESOS
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Parte 2. Beneficios: Si algún miembro de su hogar recibe SNAP, TANF, o FDPIR, proporcione el nombre y el número de elegibilidad de la persona que recibe los beneficios. **Si nadie recibe estos beneficios, vaya a la parte 4.**

NOMBRE: _____ NÚMERO DE ELEGIBILIDAD: _____

Parte 3. (Aplica solamente para padres/guardianes de niños inscritos en guarderías en hogar) Si algún miembro de su hogar recibe beneficios que se encuentren en la *Lista de Programas de asistencia Federales/Estatales (H1660),* proporcione el nombre del programa y el número de elegibilidad:

NOMBRE: _____ NÚMERO DE ELEGIBILIDAD: _____

Marque aquí si no hay ningún número de elegibilidad ☐

Parte 4. Ingreso bruto total de su hogar – Usted debe decirnos cuánto es y la frecuencia en que lo recibe

A. Nombre (Pon ga **sólo** los miembros del hogar que tengan ingresos)	**B. Ingreso bruto y frecuencia en que lo recibe** SÓLO para los que trabajan por cuenta propia, indique ingresos después de gastos en la Casilla 1			
	1. Ganancias del trabajo antes de deducciones	2. Asistencia pública, manutención de niños, pensión alimenticia	3. Pensiones, jubilación, Seguro Social, beneficios de SSI, VA	4. Todo ingreso adicional
(Ejemplo) Jane Smith	$200/semanales	$150/dos veces por mes	$100/mensuales	$200/cada 2 meses
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Nombre del centro

Parte 5. Firma y los cuatro últimos dígitos del número de Seguro Social (Un adulto debe firmar)

Una persona adulta de este hogar debe firmar esta forma. **Si se llena la Parte 4, el adulto que firma la forma debe además anotar los cuatro últimos dígitos de su número de Seguro Social o marcar la cajilla que dice: "Yo no tengo número de Seguro Social".** (Vea la Declaración del Acta de Privacidad en la próxima página.)

Yo certifico que toda la información en esta forma es verdadera y se ha reportado todos los ingresos. Yo entiendo que el centro o casa de guardería recibirá fondos Federales a base de la información que yo presento. Yo entiendo que los funcionarios de CACFP puedan verificar la información. Yo entiendo que si doy información que sé que es falsa, las personas que reciben las comidas pueden perder esos beneficios, y yo podría ser procesado legalmente.

Firme aquí: _____ Nombre con letra de molde: _____

Fecha: _____

Dirección: _____ Número de teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Cuatro últimos dígitos del Número del Seguro Social: ***-**-__ __ __ __ ❑ Yo no tengo Número de Seguro Social

Parte 6. Identidad étnica o racial del participante (opcional)

Anote una identidad étnica:	Anote una o más identidades raciales:
☐ hispano o latino ☐ No hispano ni latino	☐ Asiático ☐ Indígena Norteamericano o Nativo de Alaska ☐ Blanco ☐ Hawaiiano o de otra isla del Pacífico ☐ Negro o Africano-Americano

Parte 7. Compartir información con otros programas: OPTATIVO

La información de arriba sobre ingresos del hogar puede divulgarse con el fin de inscribir a los niños en el Programa de Seguro de Salud para Niños (CHIP). Los padres/tutores no están obligados a dar consentimiento respecto a dicha divulgación y el optar por no divulgar no afectará adversamente a los beneficios del niño.

☐ **Sí acepto que la información de mi familia sea divulgada.**

☐ **No acepto que la información de mi familia sea divulgada.**

No rellene esta parte. Esto es para uso oficial solamente.

Conversión de Ingresos Anuales: Semanal x 52, Cada 2 semanas x 26, Dos veces por Mes x 24, Mensual x 12

Ingresos totales: _____ Por: ❑ Semana, ❑ Cada 2 semanas, ❑ Dos veces por mes, ❑ Mes, ❑ Año Tamaño de la familia: _____

Calificación categórica: ____ Fecha retirado: _____ Calificación: Gratuita___ Reducida___ Negada___ Nivel I_____ Nivel II____

Motivo: _____

Firma del Funcionario que Decide: _____ Fecha: _____

Firma del Funcionario que Confirma: _____ Fecha: _____

Firma del Funcionario que hace el seguimiento: _____ Fecha: _____

Declaración del Acta de Privacidad
La Ley Nacional de Almuerzo Escolar Richard B. Russell exige la información que se pide en esta solicitud. Usted no está obligado a dar la información, pero si se niega a hacerlo, no podemos aprobar que el participante reciba comidas gratis o a un precio reducido. Usted debe incluir los cuatro últimos dígitos del número de Seguro Social de la persona adulta de su hogar quien firma la solicitud. El número del Seguro Social no es necesario cuando aplica como representante de un niño adoptivo o indica un número de elegibilidad de los siguientes programas: Programa de Asistencia de Nutrición Suplementaria (SNAP), Asistencia Temporal para Familias Necesitadas (TANF) o el programa de distribución de alimentos en reservaciones indígenas (FDPIR). El número de elegibilidad puede ser del participante u otro identificador (FDPIR) o cuando se indica que algún miembro adulto de la familia firme y no tenga un número del Seguro Social. Nosotros utilizaremos la información para determinar si el participante califica para recibir comidas gratis de precio reducido, así como para la administración y el cumplimiento legal del programa.

Declaración de No Discriminación:
Para todos los demás programas de asistencia de nutrición del FNS, agencias estatales o locales y sus subreceptores, deben publicar la siguiente Declaración de No Discriminación: De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación sexual), discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: *https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf*, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

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

(2) fax:
(833) 256-1665 o (202) 690-7442; o

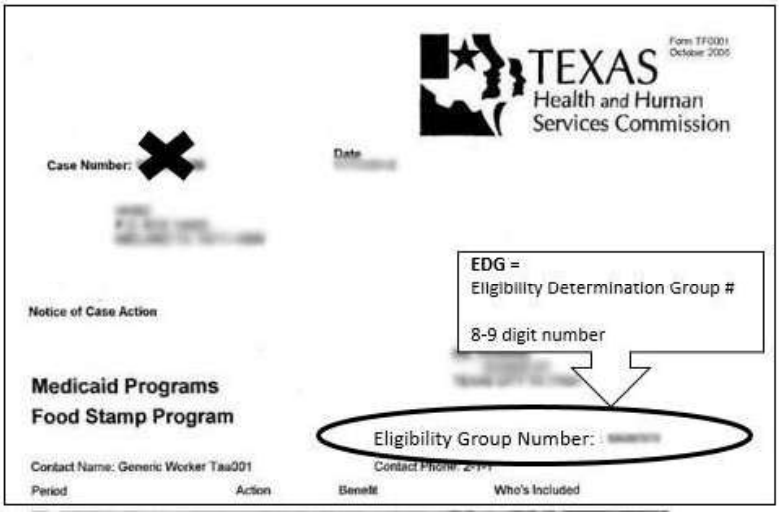
(3) correo electrónico:
program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.

INSTRUCCIONES PARA LLENAR EL FORMULARIO DE CALIFICACIÓN POR INGRESOS PARA EL BENEFICIO DE COMIDAS DE CACFP (Cuidados para niños)

Siga estas instrucciones si su hogar recibe SNAP, TANF o FDPIR:

Parte 1: Indique todos los niños y los miembros del hogar que están inscritos.
Parte 2: Indique el número de elegibilidad de cualquier miembro del hogar (incluyendo adultos) que reciba beneficios SNAP, TANF, FDPIR, SSI o Medicaid. El número SNAP o TANF debe ser el #EDG de 9 o 8 dígitos que es asignado por HHSC.
Parte 3: Omita esta parte.
Parte 4: Omita esta parte.
Parte 5: Firme el formulario. Los cuatro últimos dígitos del Número del Seguro Social no son necesarios.
Parte 6: Responda esta pregunta si quiere.
Parte 7: Responda esta pregunta si quiere.



Si está presentando una solicitud en nombre de un NIÑO DE CRIANZA, siga estas instrucciones:

Si **todos** los niños para los que presenta la solicitud son niños de crianza, o si solamente está solicitando beneficios para el niño de crianza:

Parte 1: Indique todos los niños de crianza. Marque la casilla que indica que el niño es un niño de crianza.
Parte 2: Omita esta parte.
Parte 3: Omita esta parte.
Parte 4: Omita esta parte.
Parte 5: Firme el formulario. El Número de Seguro Social **no** es necesario.
Parte 6: Responda esta pregunta si quiere.
Parte 7: Responda esta pregunta si quiere.

Si algunos de los niños del hogar son niños de crianza.

Parte 1: Indique todos los niños y los miembros del hogar que están inscritos. Para las personas, incluyendo los niños, que no tienen ingresos, debe marcar la casilla que dice "No Ingresos". Marque la casilla si el niño es un niño de crianza.
Parte 2: Si el hogar no tiene un número de elegibilidad favor de omitir esta parte.
Parte 3: Se aplica sólo a los padres/tutores de niños en Hogares de Guarderías de Nivel II. Los patrocinadores deben entregar la *Lista de Programas con Financiación Federal / Estatal que Califican* (H1660), junto con este formulario a los hogares que tienen niños inscritos en Hogares de Guarderías de Nivel II. Los padres/tutores pueden indicar el nombre del programa y el número según corresponda.
Parte 4: Siga estas instrucciones para notificar los ingresos totales del hogar de este mes o del último mes.
Columna A – Nombre: Indique sólo el primero y el último nombre de **cada** persona que viva en su hogar y que comparta ingresos y gastos, relacionados o no con ingresos (por ejemplo, abuelos, otros parientes o amigos que viven con usted). Inclúyase usted y a todos los niños que viven con usted. De ser necesario, adjunte otra hoja.
Columna B – Ingresos brutos y con cuánta frecuencia se recibieron: Por cada miembro del hogar, indique cada tipo de ingresos recibidos durante el mes. Debe informarnos con cuánta frecuencia se recibe el dinero: semanalmente, cada dos semanas, dos veces por mes, o mensualmente.

Casilla 1: Indique los **ingresos brutos**, no el salario neto. Los ingresos brutos son la cantidad obtenida antes de los impuestos y **otras deducciones**. **Puede encontrar esto en el talonario o su jefe puede decírselo.**

Casilla 2: Indique la cantidad que recibió cada persona durante el mes, por asistencia social, manutención de hijos, pensión alimenticia.

Casilla 3: Indique los beneficios de jubilación, Seguro Social, Ingresos Suplementarios del Seguro Social (SSI), beneficios para Veteranos (VA), beneficios por discapacidad.

Casilla 4: Indique TODAS LAS DEMÁS FUENTES DE INGRESOS incluyendo Indemnización de Trabajadores, desempleo, indemnización por huelga, aportes regulares de personas que no viven en su casa y cualquier otro ingreso. *SÓLO para los que trabajan por cuenta propia, indique ingresos después de gastos en la Casilla 1*. La Casilla 4 es para su empresa, hacienda o propiedad arrendada. No incluya los ingresos por beneficios de SNAP, TANF, FDPIR, WIC o federales para educación. Si está en la Iniciativa Militar de Privatización de la Vivienda o recibe un sueldo por combate, no incluya esa pensión de vivienda como ingresos.

Parte 5: El miembro adulto del hogar debe firmar el formulario e indicar los últimos cuatro dígitos del Número del Seguro Social o marcar la casilla si no tiene uno.

Parte 6: Responda esta pregunta si quiere.

Parte 7: Responda esta pregunta si quiere.

TODOS LOS DEMÁS HOGARES, incluyendo los hogares WIC, deben seguir estas instrucciones:

Parte 1: Indique todos los niños y los miembros del hogar que están inscritos. Para las personas, incluyendo los niños, que no tienen ingresos, debe marcar la casilla que dice “No Ingresos”.

Parte 2: Omita esta parte.

Parte 3: Omita esta parte.

Parte 4: Siga estas instrucciones para notificar los ingresos totales del hogar de este mes o del último mes.

Columna A – Nombre: Indique sólo el primero y el último nombre de **cada** persona que viva en su hogar y que comparta ingresos y gastos, relacionados o no con ingresos (por ejemplo, abuelos, otros parientes o amigos que viven con usted). Inclúyase usted y a todos los niños que viven con usted. De ser necesario, adjunte otra hoja.

Columna B – Ingresos brutos y con cuánta frecuencia se recibieron: Por cada miembro del hogar, indique cada tipo de ingresos recibidos durante el mes. Debe informarnos con cuánta frecuencia se recibe el dinero: semanalmente, cada dos semanas, dos veces por mes, o mensualmente.

Casilla 1: Indique los **ingresos brutos**, no el salario neto. Los ingresos brutos son la cantidad obtenida antes de los impuestos y otras deducciones. Puede encontrar esto en el talonario o su jefe puede decírselo.

Casilla 2: Indique la cantidad que recibió cada persona durante el mes, por asistencia social, manutención de hijos, pensión alimenticia.

Casilla 3: Indique los beneficios de jubilación, Seguro Social, Ingresos Suplementarios del Seguro Social (SSI), beneficios para Veteranos (VA), beneficios por discapacidad.

Casilla 4: Indique TODAS LAS DEMÁS FUENTES DE INGRESOS incluyendo Indemnización de Trabajadores, desempleo, indemnización por huelga, aportes regulares de personas que no viven en su casa y cualquier otro ingreso. *SÓLO para los que trabajan por cuenta propia, indique ingresos después de gastos en la Casilla 1*. La Casilla 4 es para su empresa, hacienda o propiedad arrendada. No incluya los ingresos por beneficios de SNAP, FDPIR, WIC o federales para educación. Si está en la Iniciativa Militar de Privatización de la Vivienda o recibe un sueldo por combate, no incluya esa pensión de vivienda como ingresos.

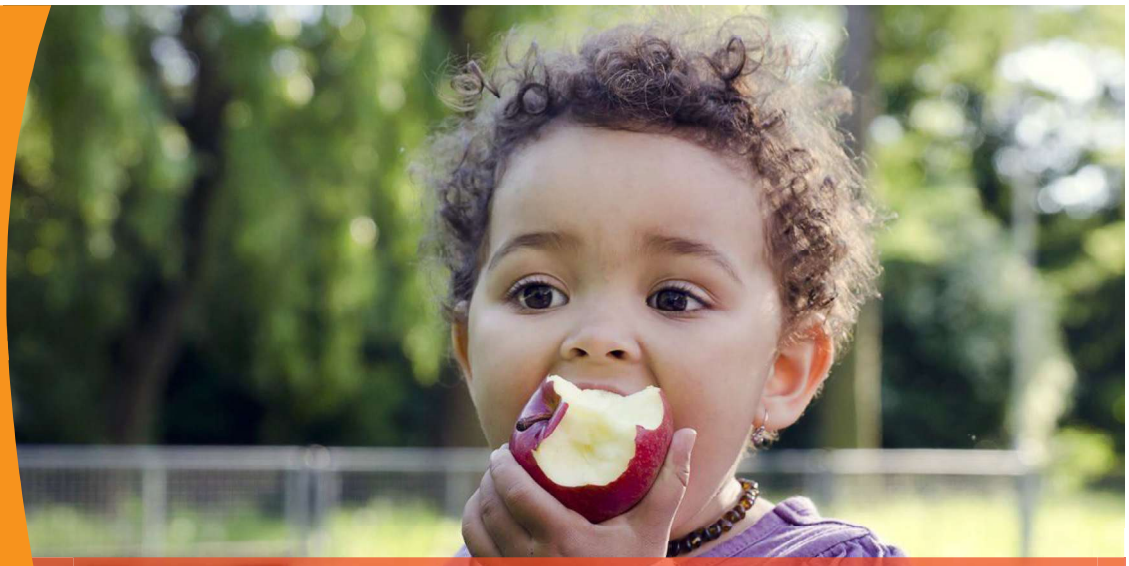
Parte 5: El miembro adulto del hogar debe firmar el formulario e indicar los últimos cuatro dígitos del Número del Seguro Social o marcar la casilla si no tiene uno.

Parte 6: Responda esta pregunta si quiere.

Parte 7: Responda esta pregunta si quiere.

Declaración del Acta de Privacidad Esto explica cómo utilizaremos la información que nos da.

Declaración de No Discriminación: Esto explica qué debe hacer si piensa que fue tratado injustamente.



Construyendo Para El Futuro

Este cuidado infantile recibe asistencia federal en efectivo para server comidas saludables a sus hijos. Una Buena nutricion hoy en dia significa una manana mas fuerte.

Las comidas servidas aqui cumplen con los requisites de nutricion establecidos por el Programa de Alimientos para el Cuidado de Ninos y Adultos (Child and Adult Care Food Program) de USDA.

¿Preguntas? ¿Preocupaciones?

Llame gratuitamente a USDA al
1-866-873-2263

OR

División de Alimentos y Nutrición al
1-800-TELL-TDA
(835-5832)

ADVANCE Child Care, Inc.
(903) 872-5231
cacfpinfo@advcc.org

DEPARTEMENTO DE AGRICULTURA DE TEXAS
COMISIONADO SID MILLER

Línea directa de fraude: 1-866-5-FRAUD-4 o 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711
Llamada gratuita: (877) TEX-MEAL | Para personas con problemas de audición: (800) 735-2989 (TTY)

Food and Nutrition Division
Nutrition Assistance Programs

Este producto fue financiado por el USDA.
Esta institución proporciona igualdad de oportunidades.

Updated 11/17/2021
www.SquareMeals.org

Ven a WIC de Texas

Estamos aquí para servirte

"Gracias a WIC, ahora tengo las herramientas que necesito para asegurar que mi familia siga el camino hacia un estilo de vida saludable."

—Roxie, cliente de WIC

Como cliente de WIC, recibirás:

- Alimentos deliciosos
- Asesoramiento individualizado con nutricionistas
- Recetas sencillas de preparar
- Clases sobre nutrición
- Apoyo para la lactancia
- Evaluaciones médicas y sobre las vacunas
- Demostraciones de cocina
- Apoyo personalizado
- Actividades para niños

¿Calificas?

Ocho millones de mujeres, bebés y niños reciben beneficios de WIC. El Programa WIC va dirigido a mujeres embarazadas, nuevos padres, bebés y niños menores de cinco años. Si ya recibes Medicaid, TANF o SNAP, es posible que califiques.

Requisitos de ingresos de WIC de Texas

Número de personas en el hogar*	Ingresos mensuales	Ingresos anuales
2	$ 3,152	$ 37,814
3	$ 3,981	$ 47,767
4	$ 4,810	$ 57,720
5	$ 5,640	$ 67,673
6	$ 6,469	$ 77,626

Vigente a partir del 1 de abril de 2024

* El número de personas en el hogar de una mujer embarazada aumenta de acuerdo con el número de bebés que espera. Si tienes alguna pregunta relacionada con los ingresos, llama al 1-800-942-3678.

Empieza hoy mismo. Llama al 1-800-942-3678 o visita TexasWIC.org

TEXAS Health and Human Services | TEXAS WIC

Esta institución es un proveedor que ofrece igualdad de oportunidades. Rev. 4/24