

## 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? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian <i>(if different from the child's)</i> :		
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? <input type="radio"/> Yes <input type="radio"/> No
<b>In case of an emergency, call:</b>			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation <b>to release</b> my child to leave the child care operation <b>ONLY</b> 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).

- |  |   |
|--|---|
| <input type="checkbox"/> Discipline and guidance   | <input type="checkbox"/> Procedures for release of children   |
| <input type="checkbox"/> Suspension and expulsion  | <input type="checkbox"/> Illness and exclusion criteria   |
| <input type="checkbox"/> Emergency plans   | <input type="checkbox"/> Procedures for dispensing medications  |
| <input type="checkbox"/> Procedures for conducting health checks   | <input type="checkbox"/> Immunization requirements for children   |
| <input type="checkbox"/> Safe sleep  | <input type="checkbox"/> Meals and food service practices   |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director  | <input type="checkbox"/> Procedures to visit the center without securing prior approval   |
| <input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | <input type="checkbox"/> Procedures for supporting inclusive services   |
| <input type="checkbox"/> Procedures for parents to participate in operation activities                                       | <input type="checkbox"/> 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)**

- |  |   |
|--|---|
| <input type="checkbox"/> Environmental allergies                               | <input type="checkbox"/> Limitations or restrictions on child's activities      |
| <input type="checkbox"/> Food intolerances                                     | <input type="checkbox"/> Reasonable accommodations or modifications             |
| <input type="checkbox"/> Existing illness                                      | <input type="checkbox"/> Adaptive equipment <i>(include instructions below)</i> |
| <input type="checkbox"/> Previous serious illness                              | <input type="checkbox"/> Symptoms or indications of complications               |
| <input type="checkbox"/> Injuries and hospitalizations <i>(past 12 months)</i> | <input type="checkbox"/> Medications prescribed for continuous long-term use    |
| <input type="checkbox"/> Other: _____  |   |

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**



### 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](http://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



## 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](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](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](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

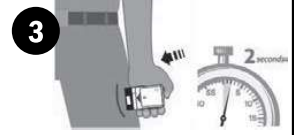
\_\_\_\_\_  
HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE

\_\_\_\_\_  
DATE



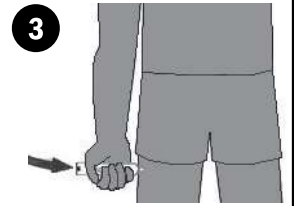
**HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO**

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.



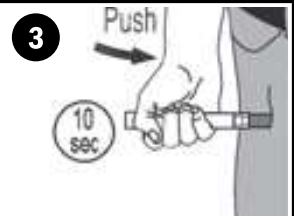
**HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION**

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.



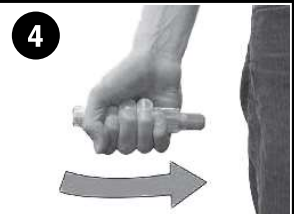
**HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS**

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: \_\_\_\_\_

# 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
<input type="checkbox"/> <b>Whole Milk:</b> Replaced With _____ Unflavored Lactose Free/Reduced Whole Milk (1 yr olds only) <span style="padding-left: 150px;">Brand Name</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Whole Milk:</b> Replaced With _____ Unflavored Soy Milk (1 yr olds only) <span style="padding-left: 150px;">Brand Name</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
=====			
<input type="checkbox"/> <b>1% Milk:</b> Replaced With _____ Unflavored Lactose Free/Reduced 1% Milk (2 -5 yr olds only) <span style="padding-left: 150px;">Brand Name</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>1% Milk:</b> Replaced With _____ Unflavored Soy Milk (2 - 5 yr olds only) <span style="padding-left: 150px;">Brand Name</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
=====			
<input type="checkbox"/> <b>1% Milk:</b> Replaced With _____ [ ] Unflavored [ ] Flavored Lactose Free/Reduced 1% Milk (6 -18 yr olds only) <span style="padding-left: 150px;">Brand Name</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>1% Milk:</b> Replaced With _____ [ ] Unflavored [ ] Flavored Soy Milk (6 -18 yr olds only) <span style="padding-left: 150px;">Brand Name</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
=====			
<input type="checkbox"/> _____ Replaced With _____ <span style="padding-left: 100px;">Scheduled Component</span> <span style="padding-left: 300px;">Substituted Component</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____ Replaced With _____ <span style="padding-left: 100px;">Scheduled Component</span> <span style="padding-left: 300px;">Substituted Component</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____ Replaced With _____ <span style="padding-left: 100px;">Scheduled Component</span> <span style="padding-left: 300px;">Substituted Component</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____ Replaced With _____ <span style="padding-left: 100px;">Scheduled Component</span> <span style="padding-left: 300px;">Substituted Component</span>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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.

<b>CHILD INFORMATION</b>			
Center Enroll Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Ethnic Identity (Check one)</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino  <b>Racial Identity (Check all that apply)</b> <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander  <b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>SITE / SPONSOR USE ONLY</b>  Withdrawal Date: ___/___/___ Re-Enroll Date: ___/___/___
Child's First Name	<input style="width: 100%;" type="text"/>		
Child's Last Name	<input style="width: 100%;" type="text"/>		
Child's Birth Date	<input type="text"/> / <input type="text"/> / <input type="text"/>		
Normal Days in Care <small>Center's Days of Operation:</small>	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU		
Normal Hours in Care <small>Center's Hours of Operation:</small>	<input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
Meals/Snacks Child Receives <small>Meals/Snacks Served at Center:</small>	<input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS		
Center Enroll Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Ethnic Identity (Check one)</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino  <b>Racial Identity (Check all that apply)</b> <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander  <b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>SITE / SPONSOR USE ONLY</b>  Withdrawal Date: ___/___/___ Re-Enroll Date: ___/___/___
Child's First Name	<input style="width: 100%;" type="text"/>		
Child's Last Name	<input style="width: 100%;" type="text"/>		
Child's Birth Date	<input type="text"/> / <input type="text"/> / <input type="text"/>		
Normal Days in Care <small>Center's Days of Operation:</small>	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU		
Normal Hours in Care <small>Center's Hours of Operation:</small>	<input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
Meals/Snacks Child Receives <small>Meals/Snacks Served at Center:</small>	<input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS		
Center Enroll Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Ethnic Identity (Check one)</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino  <b>Racial Identity (Check all that apply)</b> <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander  <b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>SITE / SPONSOR USE ONLY</b>  Withdrawal Date: ___/___/___ Re-Enroll Date: ___/___/___
Child's First Name	<input style="width: 100%;" type="text"/>		
Child's Last Name	<input style="width: 100%;" type="text"/>		
Child's Birth Date	<input type="text"/> / <input type="text"/> / <input type="text"/>		
Normal Days in Care <small>Center's Days of Operation:</small>	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU		
Normal Hours in Care <small>Center's Hours of Operation:</small>	<input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM		
Meals/Snacks Child Receives <small>Meals/Snacks Served at Center:</small>	<input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS		

<b>PARENT / GUARDIAN INFORMATION</b>	
<p>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.</p> <p>_____</p> <p style="text-align: center;">Signature</p>	<p>Parent First Name <input style="width: 100%;" type="text"/></p> <p>Parent Last Name <input style="width: 100%;" type="text"/></p> <p>Cell Phone <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 40px;" type="text"/></p>
<p>_____</p> <p style="text-align: center;">Date</p>	<p style="text-align: center;"><small>SITE / SPONSOR USE ONLY</small></p>

This institution is an equal opportunity provider.



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

#### Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDIPIR, 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				C. Pensions, retirement, Social Security, SSI, VA benefits				D. All Other Income											
	1. Earnings from work before deductions				2. Welfare, child support, alimony				3. Pensions, retirement, Social Security, SSI, VA benefits				4. All Other Income							
	Weekly	Every 2 Weeks	2x Monthly	Monthly	Annually	Weekly	Every 2 Weeks	2x Monthly	Monthly	Annually	Weekly	Every 2 Weeks	2x Monthly	Monthly	Annually					
<i>Example: JJane Smith</i>	\$ 200	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ 150	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$ 100	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$ 100	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Part 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:

- Hispanic or Latino  
 Not Hispanic or Latino

Mark one or more racial identities:

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

### 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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.



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,

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

**Ingresos máximos para determinar la elegibilidad  
 para beneficios gratuitos o a precio reducido  
 1 de julio de 2023 - 30 de junio de 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.

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

## 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.

The illustration shows a portion of the form with the following elements:

- Top right: TEXAS Health and Human Services Commission logo and Form TF0001 October 2006.
- Case Number: [Redacted with a large X]
- Date: [Redacted]
- Notice of Case Action
- Medicaid Programs
- Food Stamp Program
- Contact Name: Generic Worker Taa001
- Contact Phone: 214111
- Table headers: Period, Action, Benefit, Who's Included
- Eligibility Group Number: [Redacted]
- Annotation: A box labeled "EDG = Eligibility Determination Group # 8-9 digit number" has arrows pointing to the circled Eligibility Group Number field.

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.

**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.

# 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:** \_\_\_\_\_

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**Administrator Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_