

# ENROLLMENT FORM

ENTRANCE DATE: \_\_\_\_\_

WITHDRAWAL DATE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
IF DIFFERENT FROM CHILD'S

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

FATHER'S PLACE OF EMPLOYMENT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

HOME ADDRESS (STREET): \_\_\_\_\_  
IF DIFFERENT FROM CHILD'S

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MOTHER'S PLACE OF EMPLOYMENT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CHILD'S LIVING ARRANGEMENTS: \_\_\_\_\_ BOTH PARENTS \_\_\_\_\_ MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_ OTHER  
CHECK ONE

CHILD'S LEGAL GUARDIAN(S): \_\_\_\_\_ BOTH PARENTS \_\_\_\_\_ MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_ OTHER  
CHECK ONE

**THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:**

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

HOME ADDRESS (STREET): \_\_\_\_\_  
IF DIFFERENT FROM CHILD'S

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

RELATIONSHIP TO PARENT(S): \_\_\_\_\_

OTHER IDENTIFYING INFORMATION: \_\_\_\_\_  
IF ANY

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

HOME ADDRESS (STREET): \_\_\_\_\_  
IF DIFFERENT FROM CHILD'S

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

RELATIONSHIP TO PARENT(S): \_\_\_\_\_

OTHER IDENTIFYING INFORMATION: \_\_\_\_\_  
IF ANY

**PERSON(S) TO CONTACT IN THE CASE OF EMERGENCY WHEN THE PARENT OR GUARDIAN CANNOT BE REACHED:**

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

NAME OF PUBLIC OR PRIVATE SCHOOL CHILD ATTENDS, IF ANY: \_\_\_\_\_

CHILD'S PHYSICIAN NAME OR CLINIC NAME: \_\_\_\_\_

PHYSICIAN | CLINIC PHONE NUMBER: \_\_\_\_\_

MY CHILD HAS THE FOLLOWING SPECIAL NEEDS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THE FACILITY:

\_\_\_\_\_  
\_\_\_\_\_

MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ILLNESS, ALLERGIES, OR HEALTH CONCERNS:

\_\_\_\_\_  
\_\_\_\_\_

# EMERGENCY MEDICAL AUTHORIZATION

IN THE EVENT (CHILD'S NAME) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SUFFERS AN INJURY OR ILLNESS WHILE IN THE CARE OF KIDSTOP DAYCARE AND LEARNING CENTER

AND THE FACILITY IS UNABLE TO CONTACT ME (PARENT | GUARDIAN) IMMEDIATELY, IT SHALL BE AUTHORIZED TO  
SECURE SUCH MEDICAL ATTENTION AND CARE FOR THE CHILD AS MAY BE NECESSARY.

I (PARENT | GUARDIAN) SHALL ASSUME RESPONSIBILITY FOR PAYMENT FOR SERVICES.

PARENT | GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

FACILITY ADMINISTRATOR : \_\_\_\_\_

DATE: \_\_\_\_\_

# PARENTAL AGREEMENTS WITH CHILD CARE FACILITY

THE **KIDSTOP DAYCARE AND LEARNING CENTER** AGREES TO PROVIDE CHILD CARE FOR  
[FACILITY NAME]  
[CHILD NAME] ON **MONDAY - FRIDAY**  
[DAYS OF WEEK]  
**6** TO **6:30** FROM **JANUARY** TO **DECEMBER**  
AM PM MONTH MONTH

**MY CHILD WILL PARTICIPATE IN THE FOLLOWING MEAL PLAN:**  
**CIRCLE APPLICABLE MEALS AND SNACKS**

- BREAKFAST
- MORNING SNACK
- LUNCH
- AFTERNOON SNACK
- EVENING SNACK
- DINNER
- BEDTIME SNACK

BEFORE ANY MEDICATION IS ADMINSTRERED TO MY CHILD, I WILL PROVIDE A WRITTEN AUTHORIZATION, WHICH INCLUDES: DATE, NAME OF CHILD, NAME OF MEDICATION, PRESCRIPTION NUMBER, DOSAGE(S), DAY(S) AND TIME MEDICATION IS TO BE GIVEN. MEDICINE WILL BE IN THE ORIGINAL CONTAINER WITH MY CHILD’S NAME MARKED ON IT.

MY CHILD WILL NOT BE ALLOWED TO ENTER OR LEAVE THE FACILITY WITHOUT BEING ESCORTED BY THE PARENT(S), A PERSON AUTHORIZED BY PARENT(S), OR FACILITY PERSONNEL.

I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO KEEP MY CHILD’S RECORD CURRENT TO REFLECT ANY SIGNIFICANT CHANGES AS THEY OCCUR, I.E. TELEPHONE NUMBERS, WORK LOCATION, EMERGENCY CONTACT, CHILD’S PHYSICIAN, CHILD’S HEALTH STATUS, INFANT FEEDING PLANS AND IMMUNIZATION RECORDS, ETC.

THE FACILITY AGREES TO KEEP ME INFORMED OF ANY INCIDENTS, INCLDUING ILLNESSES, INJURIES, ADVERSE REACTIONS TO MEDICATIONS, ETC., WHICH INCLUDE MY CHILD.

**KIDSTOP DAYCARE AND LEARNING CENTER** AGREES TO OBTAIN WRITTEN AUTHORIZATION FROM ME BEFORE MY CHILD PARTICIPATES IN ROUTINE TRANSPORTATION, FIELD TRIPS, SPECIAL ACTIVITIES AWAY FROM THE FACILITY, AND WATER-RELATED ACTIVITIES OCCURRING IN WATER THAT IS MORE THAN TWO (2) FEET DEEP.

I AUTHORIZE THE CHILD CARE FACILITY TO OBTAIN EMERGENCY MEDICAL CARE FOR MY CHILD WHEN I AM NOT AVAILABLE.

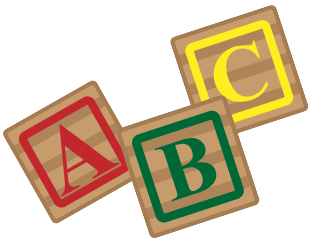
I HAVE RECEIVED A COPY AND AGREE TO ABIDE BY THE POLICIES AND PROCEDURES FOR **KIDSTOP DAYCARE AND LEARNING CENTER**

I UNDERSTAND THAT THE FACILITY WILL ADVISE ME OF MY CHILD’S PROGRESS AND ISSUES RELATING TO MY CHILD’S CARE AS WELL AS ANY INDIVIDUAL PRACTICES CONCERNING MY CHILD’S SPECIAL NEEDS. I ALSO UNDERSTAND THAT MY PARTICIPATION IS ENCOURAGED IN FACILITY ACTIVITIES.

I AUTHORIZE THE CHILD CARE FACILITY TO OBTAIN EMERGENCY MEDICAL CARE FOR MY CHILD WHEN I AM NOT AVAILABLE.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
PARENT | GUARDIAN

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
FACILITY ADMINISTRATOR



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## TUITION FEES

Effective December 1, 2023

6 WEEKS- 11 MONTHS	12 MONTHS- 23 MONTHS	2 YEARS	3 YEARS	4 YEARS
<b>\$185</b> WEEKLY	<b>\$175</b> WEEKLY	<b>\$165</b> WEEKLY	<b>\$155</b> WEEKLY	<b>\$145</b> WEEKLY

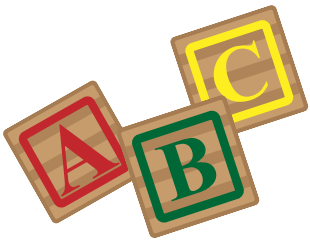
## PROGRAMS OFFERED:

**AFTER-SCHOOL PROGRAM** \_\_\_\_\_ **\$75 | WEEKLY**  
RATE INCLUDES 4 HRS PER DAY

## OTHER FEES:

<b>SUMMER RATE   FULL TIME</b>	<b>\$130</b> WEEKLY
<b>OCCASIONAL RATE</b> i.e., SPRING   WINTER   CHRISTMAS BREAKS	<b>\$130</b> WEEKLY
<b>DAILY   DROP IN RATE</b>	<b>\$40</b> PER DAY   PER CHILD
<b>REGISTRATION FEE</b> NON-REFUNDABLE	<b>\$75</b>
<b>LATE PICKUP</b>	<b>\$1</b> A MINUTE AFTER 6:00PM
<b>LATE TUITION FEE</b>	<b>15%</b> OF TUITION AFTER WEDNESDAY
<b>RETURNED CHECK FEE</b>	<b>\$30</b>
<b>B A PREK</b>	<b>\$100</b>





## ATTENTION PARENTS

**PARENTS ARE RESPONSIBLE FOR WEEKLY PAYMENTS  
REGARDLESS OF YOUR CHILD ATTENDING THE CENTER.**

**NO EXCEPTIONS!**

ALL PAYMENTS ARE DUE ON MONDAY.  
IF YOUR PAYMENT IS NOT RECEIVED BY WEDNESDAY, THERE WILL BE A LATE  
FEE OF **15%** THAT WILL BE ADDED TO YOUR WEEKLY FEE.

CAPS POLICY STATES THAT PARENTS WHO ARE APPROVED FOR SUBSIDY  
FUNDS FROM THE CAPS PROGRAM PARTICIPATE IN THEIR COST OF CARE BY  
PAYING A FAMILY ASSESSED FEE.

FAMILY FEES ARE CALCULATED BY THE CAPS CASE MANAGER AND ARE BASED  
ON THE FAMILY'S ANNUAL GROSS INCOME AND THE NUMBER OF CHILDREN  
RECEIVING SUBSIDIZED CHILD CARE.

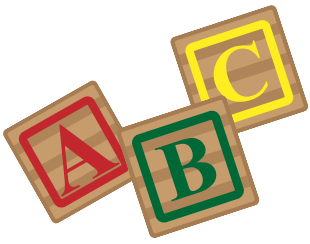
THE ASSESSED FEE IS A FAMILY FEE, NOT A 'PER CHILD' FEE. THE PARENT IS  
RESPONSIBLE FOR PAYING THE ASSESSED FEE DIRECTLY TO THEIR CHILD  
CARE PROVIDER AS LONG AS THE CHILD IS ENROLLED, WHETHER THEY  
ATTEND THE PROGRAM FOR THE ENTIRE WEEK OR NOT.

THE PARENT IS TO PAY THE TOTAL AMOUNT OF THE ASSESSED FEE ON THE  
FIRST DAY OF SERVICE. NON-PAYMENT OF THE WEEKLY ASSESSED FEE MAY  
RESULT IN TERMINATION OF SERVICES FROM THE CAPS PROGRAM UNTIL  
OUTSTANDING FEES ARE PAID IN FULL. IF YOU HAVE A PARENT WITH A CHILD IN  
YOUR CASE THAT HAS NOT PAID THEIR WEEKLY ASSESSED FEE, PLEASE  
CONTACT CAPS.

**THANK YOU IN ADVANCE FOR YOUR COOPERATION.**

*T. Robinson*





## TYPICAL CLASSROOM DAILY SCHEDULE

6:00-8:00 AM	ARRIVAL   FREE PLAY
8:00 - 9:00 AM	BREAKFAST   FREE PLAY
8:45 - 9:00 AM	CIRCLE TIME   DEVOTION   FREE PLAY
9:00 - 10:00 AM	CENTER TIME   FREE PLAY
10:00 - 10:15 AM	CENTER TIME   CLEAN UP
10:15 - 11:00 AM	OUTDOOR   INDOOR PLAY WEATHER PERMITTING
11:05 - 11:15 AM	STORY TIME   HAND WASHING   FREE PLAY
11:15 - 11:45 AM	LUNCH TIME   FREE PLAY
11:45 - 12:00 PM	LARGE GROUP LITERACY   SOCIOEMOTIONAL TIME   FREE PLAY
12:00 - 2:00 PM	NAP   QUIET TIME   STORY TIME
2:00 - 2:30 PM	SNACK TIME   FREE PLAY
2:30 - 2:45 PM	STORY TIME   FREE PLAY
2:45 - 3:15 PM	CENTER TIME   FREE PLAY
3:15 - 4:00 PM	OUTDOOR   INDOOR PLAY
4:00 - 4:30 PM	ARTS + CRAFTS   FREE PLAY
4:30 - 4:45 PM	MUSIC & MOVEMENT   FREE PLAY
4:45 - 5:00 PM	CLOSING CIRCLE   FREE PLAY
5:00 - 6:00 PM	FREE PLAY   DEPARTURE





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## ATTENTION PARENTS

**BEADS AND SMALL BARRETES ARE  
NOT ALLOWED IN CHILDREN'S HAIR.**

**IT IS OUR POLICY FOR CHILDREN NOT TO WEAR SMALL  
BARRETES OR BEADS OF ANY KIND TO OUR FACILITY.**

**THANK YOU IN ADVANCE FOR YOUR COOPERATION.**

*T. Robinson*







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## **ATTENTION PRESCHOOL PARENTS**

**YOUR CHILD IS REQUIRED TO WEAR  
UNIFORMS MONDAY-THURSDAY.**

**PLEASE INQUIRE IN THE FRONT OFFICE FOR YOUR  
CHILD'S SHIRT SIZE AND PRICING.**

**PLEASE ADHERE TO THE POLICIES OF KIDSTOP  
DAYCARE AND LEARNING CENTER.**

**THANK YOU**





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## ATTENTION PARENTS

**EFFECTIVE IMMEDIATELY, PLEASE BRING THE FOLLOWING DOCUMENTS WHEN YOUR CHILD HAS BEEN SEEN BY A PHYSICIAN:**



**A DOCUMENT STATING THAT YOUR CHILD WAS SEEN, AND WHAT YOUR CHILD WAS DIAGNOSED WITH.**



**A DOCUMENT STATING WHEN YOUR CHILD CAN RETURN TO THE CENTER.**



**PROOF OF PURCHASE OF MEDICATION**

**YOUR CHILD WILL NOT BE ABLE TO RETURN TO SCHOOL, WITHOUT ALL DOCUMENTS.**

**NO EXCEPTIONS!**

**THANK YOU IN ADVANCE FOR YOUR COOPERATION**

*T. Robinson*





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## ATTENTION PARENTS

IF YOU PARTICIPATE IN THE CAPS PROGRAM AND YOUR CHILD IS  
**ABSENT FOR ANY REASON:**

### INCLUDING

WINTER BREAK

SPRING BREAK

FALL BREAK

CHRISTMAS BREAK

SUMMER BREAK

YOU ARE STILL RESPONSIBLE FOR YOUR WEEKLY  
CO-PAYMENT, AS LONG AS YOUR CHILD IS ENROLLED AT KIDSTOP  
DAYCARE AND LEARNING CENTER.





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# WIC

**A SPECIAL FOOD AND NUTRITION EDUCATION PROGRAM  
FOR WOMEN, INFANTS AND CHILDREN.**

## WHO IS ELIGIBLE:

- A PREGNANT WOMAN
- A BREASTFEEDING WOMAN
- A WOMAN WHO HAS RECENTLY BEEN PREGNANT
- AN INFANT OR A CHILD LESS THAN 5 YEARS OLD

## TO BE ELIGIBLE, YOU MUST ALSO:

HAVE LOW OR MODERATE INCOME

**AND**

HAVE A SPECIAL NEED THAT CAN BE  
HELPED BY WIC FOODS AND  
NUTRITION COUNSELING

## SERVICES PROVIDED:

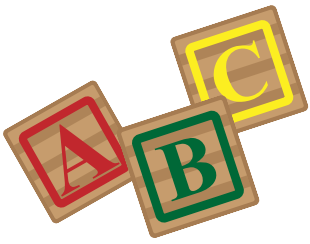
- NUTRITIOUS FOODS
- NUTRITION COUNSELING
- BREAST FEEDING SUPPORT
- HEALTH CARE REFERRAL

## APPROVED WIC FOODS:

- MILK
- CHEESE
- EGGS
- CEREALS
- PEANUT BUTTER
- FRUIT
- VEGETABLE JUICES
- DRY BEANS
- PEAS
- IRON FORTIFIED FORMULA

**YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY  
CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION**





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## DEAR PARENT(S) OR GUARDIAN(S):

THIS LETTER IS INTENDED FOR PARENT(S) OR GUARDIAN(S) OF CHILDREN ENROLLED IN A CHILD CARE CENTER.

**KIDSTOP DAYCARE AND LEARNING CENTER** OFFERS HEALTHY MEALS TO ALL ENROLLED CHILDREN AS PART OF OUR PARTICIPATION IN THE U.S. DEPARTMENT OF AGRICULTURE'S (USDA) CHILD AND ADULT CARE FOOD PROGRAM (CACFP). THE CACFP PROVIDES REIMBURSEMENTS 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: **[KIDSTOP DAYCARE AND LEARNING CENTER | 2395 CAMPBELLTON RD ATLANTA, GA 30311]**.

### 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 (FDPRI) BENEFITS CAN GET FREE MEALS. FOSTER CHILDREN AND CHILDREN ENROLLED IN HEAD START ARE ALSO ELIGIBLE FOR FREE MEALS. CHILDREN IN HOUSEHOLDS PARTICIPATING IN WIC MAY BE ELIGIBLE FOR FREE MEALS.

### 3. WHO CAN GET REDUCED PRICE MEALS?

YOUR CHILDREN CAN GET LOW COST MEALS IF YOUR HOUSEHOLD INCOME IS WITHIN THE REDUCED PRICE LIMITS ON THE FEDERAL INCOME CHART, SHOWN ON THIS APPLICATION. CHILDREN IN HOUSEHOLDS PARTICIPATING IN WIC MAY BE ELIGIBLE FOR REDUCED PRICE MEALS.

### 4. MAY I FILL OUT A FORM IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN?

YES. YOU OR YOUR CHILDREN DO NOT HAVE TO BE U.S. CITIZENS TO QUALIFY FOR MEAL BENEFITS OFFERED AT THE CHILD CARE CENTER.

### 5. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD?

YOU MUST INCLUDE EVERYONE IN YOUR HOUSEHOLD (SUCH AS GRANDPARENTS, OTHER RELATIVES, OR FRIENDS WHO LIVE WITH YOU) WHO SHARES INCOME AND EXPENSES. YOU MUST INCLUDE YOURSELF AND ALL CHILDREN WHO LIVE WITH YOU. YOU ALSO MAY INCLUDE FOSTER CHILDREN WHO LIVE WITH YOU.

### 6. HOW DO I REPORT INCOME INFORMATION AND CHANGES IN EMPLOYMENT STATUS?

THE INCOME YOU REPORT MUST BE THE TOTAL GROSS INCOME LISTED BY SOURCE FOR EACH HOUSEHOLD MEMBER RECEIVED LAST MONTH. IF LAST MONTH'S INCOME DOES NOT ACCURATELY REFLECT YOUR CIRCUMSTANCES, YOU MAY PROVIDE A PROJECTION OF YOUR MONTHLY INCOME. IF NO SIGNIFICANT CHANGE HAS OCCURRED, YOU MAY USE LAST MONTH'S INCOME AS A BASIS TO MAKE THIS PROJECTION. IF YOUR HOUSEHOLD'S INCOME IS EQUAL TO OR LESS THAN THE AMOUNTS INDICATED FOR YOUR HOUSEHOLD'S SIZE ON THE ATTACHED INCOME CHART, THE CENTER WILL RECEIVE A HIGHER LEVEL OF REIMBURSEMENT. ONCE PROPERLY APPROVED FOR FREE OR REDUCED PRICE BENEFITS, WHETHER THROUGH INCOME OR BY PROVIDING A CURRENT SNAP, TANF, FDPRI CASE NUMBER, YOU WILL REMAIN ELIGIBLE FOR THOSE BENEFITS FOR 12 MONTHS. YOU SHOULD NOTIFY US, HOWEVER, IF YOU OR SOMEONE IN YOUR HOUSEHOLD BECOMES UNEMPLOYED AND THE LOSS OF INCOME CAUSES YOUR HOUSEHOLD INCOME TO BE WITHIN THE ELIGIBILITY STANDARDS.

### 7. WHAT IF MY INCOME IS NOT ALWAYS THE SAME?

LIST THE AMOUNT THAT YOU NORMALLY GET. FOR EXAMPLE, IF YOU NORMALLY GET \$1000 EACH MONTH, BUT YOU MISSED SOME WORK LAST MONTH AND ONLY GOT \$900, PUT DOWN THAT YOU GET \$1000 PER MONTH. IF YOU NORMALLY GET OVERTIME, INCLUDE IT, BUT NOT IF YOU ONLY GET IT SOMETIMES.

### 8. WHAT IF I HAVE FOSTER CHILDREN?

FOSTER CHILDREN THAT ARE UNDER THE LEGAL RESPONSIBILITY OF A FOSTER CARE AGENCY OR COURT ARE ELIGIBLE FOR FREE MEALS. ANY FOSTER CHILD IN THE HOUSEHOLD IS ELIGIBLE FOR FREE MEALS REGARDLESS OF INCOME. HOUSEHOLDS MAY INCLUDE FOSTER CHILDREN ON THE MEAL BENEFIT FORM, BUT ARE NOT REQUIRED TO INCLUDE PAYMENTS RECEIVED FOR THE FOSTER CHILD AS INCOME. HOUSEHOLDS WISHING TO APPLY FOR SUCH BENEFITS FOR FOSTER CHILDREN SHOULD CONTACT **BRIGHT FROM THE START**

**404-656-5957**

### 9. WE ARE IN THE MILITARY, DO WE INCLUDE OUR HOUSING AND SUPPLEMENTAL ALLOWANCES AS INCOME?

IF YOUR HOUSING IS PART OF THE MILITARY HOUSING PRIVATIZATION INITIATIVE AND YOU RECEIVE THE FAMILY SUBSISTENCE SUPPLEMENTAL ALLOWANCE, DO NOT INCLUDE THESE ALLOWANCES AS INCOME. ALSO, IN REGARD TO DEPLOYED SERVICE MEMBERS, ONLY THAT PORTION OF A DEPLOYED SERVICE MEMBER'S INCOME MADE AVAILABLE BY THEM OR ON THEIR BEHALF TO THE HOUSEHOLD WILL BE COUNTED AS INCOME TO THE HOUSEHOLD. COMBAT PAY, INCLUDING DEPLOYMENT EXTENSION INCENTIVE PAY (DEIP) IS ALSO EXCLUDED AND WILL NOT BE COUNTED AS INCOME TO THE HOUSEHOLD. ALL OTHER ALLOWANCES MUST BE INCLUDED IN YOUR GROSS INCOME.

### 10. (PRICING PROGRAM ONLY) WILL THE INFORMATION I GIVE BE VERIFIED?

MAYBE. WE MAY ASK YOU TO SEND WRITTEN PROOF TO VERIFY THE INFORMATION YOU SUBMITTED ON THE FORM. WHAT IF I DISAGREE WITH THE DECISION ABOUT THE INFORMATION I COMPLETE ON THIS FORM? YOU SHOULD TALK TO BRIGHT FROM THE START. 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 404-629-3747**

*T. Robinson*





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**BRIGHT FROM THE START: GEORGIA DEPARTMENT OF EARLY CARE AND LEARNING  
CHILD ADULT CARE FOOD PROGRAM  
INCOME ELIGIBILITY STATEMENT**

PART I: Child(ren) or Adult enrolled to receive day care-					
Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDIIR case number, Assistant Unit (AU), or Client ID number for <u>children only</u> . All the above, or SSI or Medicaid case number for <u>Adults</u> . Note: Do not use EBT numbers.			Head Start Participant	Foster Child
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

PART II A:		B. Gross income and how often it is received Example: \$100/monthly, \$100/twice a month, \$100/every other week, \$100/weekly				C. Check if NO income
A. Name (List everyone in household, including foster and non-foster children)		1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	
1. _____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
2. _____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
3. _____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
4. _____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
5. _____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
6. _____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>
7. _____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____	<input type="checkbox"/>

**PART III: ENROLLMENT INFORMATION: Children Only**

My child is normally in attendance at the facility between the hours of \_\_\_\_\_ [am/pm] to \_\_\_\_\_ [am/pm] on the following days:  
☐ Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:  
(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

**PART IV: Signature and Social Security Number (Adult must sign).**

An adult household member must sign this form. If Part II is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on 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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care.

Signature: X \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: GA Zip \_\_\_\_\_ Phone \_\_\_\_\_

Last four Digits of Social Security Number XXX-XX \_\_\_\_\_ ☐ I do not have a Social Security Number

**PART V: Participant's ethnic and racial identities (optional)**

Mark one ethnic identity:	Mark one or more racial identities:
<input type="checkbox"/> Hispanic/ Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander
<input type="checkbox"/> Not Hispanic/ Latino	

**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 \_\_\_\_\_ Paid \_\_\_\_\_ Tier I \_\_\_\_\_ Tier II \_\_\_\_\_

Temporary: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_\_\_ days)

Determining Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Follow Up Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_