GEORGIA PRE-K CHECKLIST FOR STUDENT FILES
2023-2024

_____ (child's name) is in need of the following items.

Please bring the required documentation immediately for your child's Pre-K file to be approved and completed for Georgia's Pre-K requirements.

	CHILD'S BIRTH CERTIFICATE
	PROOF OF RESIDENCE (LEASE, UTILITY BILL, CAR REGISTRATION, NOTARIZED LETTER)
	PRE-K REGISTRATION FORM (2 PAGES)
	ROSTER INFORMATION FORM (TANF/EBT CARD, MEDICAID CARD)
	PARENTAL AGREEMENTS WITH CHILD CARE FACILITY
	FOOD ALLERGY ACTION PLAN
	VEHICLE EMERGENCY MEDICAL INFORMATION
	CAPS REFERRAL FOR GEORGIA'S PRE-K PROGRAM
	W.I.C. PROGRAM ACKNOWLEGEMENT FORM
	POLICY AGREEMENT & DISCIPLINE AND BEHAVIOR POLICY FROM PARENT HANDBOOK (PAGES 9 & 11)
	PARENT'S I.D.
	PARENT'S SOCIAL SECURITY CARD
	CHILD'S SOCIAL SECURITY CARD
	IMMINIZATION RECORD (MUST BE CURRENT) FORM 3231
	3300 FORM (DENTAL, VISION, HEARING, NUTRITION)
	INCOME ELIGIBILITY FORM

Parents thank you very much for being so proactive in submitting your child's documentation

Mrs. Jasmin S. Quillian, PreK Site Director

BRIGHT from the START
Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

School Year

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |		
CHILD'S FIRST NAME: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |		
CHILD'S MIDDLE NAME: | | | | | | | | | | | | | | | | | NAME SUFFIX:| | | | (i.e. Jr, Sr, II,III)		
CHILD'S SOCIAL SECURITY#:	D.O.B. (MM/DD/BY):	SEX: [ ]M [ ]F
HOME ADDRESS (*Do not enter PO Box Info*):		COUNTY:
CITY:	STATE: GA ZIP:	HOME PHONE: ( )

If the Student is transferring from another Pre-K, please provide the following:
Previous School Name: _____ Last Date in Attendance: _____

PARENT/GUARDIAN INFORMATION		
Parent/Guardian #1 - LAST NAME:	FIRST:	MIDDLE INITIAL:
Home Address *(If different from child)*:		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	
Email Address:		
Place of Employment:	Work Phone: ( )	
Address:		
City:	State:	Zip:
Parent/Guardian #2 - LAST NAME:	FIRST:	MIDDLE INITIAL:
Home Address *(If different from child)*:		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	
Email Address:		
Place of Employment:	Work Phone: ( )	
Address:		
City:	State:	Zip:

EMERGENCY CONTACT INFORMATION **(Persons to contact in the event that either parent/guardian cannot be contacted)**

NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.				
2.				

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.

Signature Parent/Guardian: _____ **DATE:** _____

CHILD MAINTENANCE
CHILD'S LIVING ARRANGEMENTS: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER
CHILD'S LEGAL GUARDIAN: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER
THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING: NAME ADDRESS RELATIONSHIP CELL PHONE
1.
2.
3.
4.
CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): _____. DATE OF LAST FULL HEALTH SCREENING:_____ PHONE: ( )
MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):
THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:
MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate. *(Por favor escriba el nombre como aparece en el certificado de nacimiento.)*

TODAY'S DATE (M/D/Y): ____/____/____		
CHILD INFORMATION:		
Legal Last Name *(Apellido):*		Name Suffix (Sufijo) (Jr,II,III):
Legal First Name *(Primer Nombre):*		Name Child is Called:
Legal Middle Name *(Segundo Nombre):*		
Child's Social Security# ____-____-____	DOB *(Fecha de Nacimiento)* *(M/D/Y):* ____/____/____	Gender *(Sexo):* M ☐ F ☐
Date enrolled in Pre-K (M/D/Y): ____/____/____		
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	

1. Is your child's ethnicity **Hispanic/Latino/Spanish Origin,** regardless of race? *(¿Es Ud. **Hispano/Latino o de Origen Hispano,** sin importar la raza?)*

☐ **Yes** *(Si)* ☐ **No** *(No)* ☐ **Decline to Answer** *(negarse a contester)*

Please select **ONE OR MORE** of the following races regardless of how you answered question one. *(**TODOS** deben seleccionar **UNA O MAS** de las sigulentes razas sin importar cómo haya contestado la primera pregunta.)*

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. *(**Blanco** – Una persona que tiene orígenes en los pueblos provenientes de Europa, el Medio Oriente, o Africa del Norte).*

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *(**Asiática** – Una persona con orígenes en los pueblos provenientes del Lejano Oriente, Suroeste de Asia, o el subcontinente Hindú incluyendo, a Cambodia, China, India, Japón, Corea, Malasia, Pakistán, Las Filipinas, Tailandia, y Vietnam.)*

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. *(**Nativo de Hawaii u Otra Isla del Pacífico** – Una persona con orígenes en los pueblos provenientes de Hawaii, Guam, Samoa, u otra Isla del Pacifico.)*

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa. *(**Negro o Afro Americano** – Una persona con orígenes en los pueblos provenientes del Africa o en grupo racial Negro.)*

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment. *(**Indio Americano o Nativo de Alaska** – Una persona con orígenes en los pueblos provenientes de América Del Norte y del Sur, incluyendo América Central, que mantiene una afiliación tribal o comunitaria.)*

☐ f. **Decline to Answer** *(negarse a contester)*

3. What is your child's primary language? *(¿Cuál es el idioma primario de su hijo(a)?)*

☐ **English** *(Inglés)*

☐ **A language other than English** *(Un idioma diferente al Inglés)*

4. Was your child born as a: *(El parto en que Ud. tuvo a su hijo(a) fue de:)*

☐ **Single Birth (1)** *(Un sólo niño)*

☐ **Twin (2)** *(De mellizos)*

☐ **Triplet (3)** *(De trillizos)*

☐ **Quadruplet (4)** *(De cuatrillizos)*

☐ **Quintuplet (5)** *(De quintuples)*

5. Does your child have an Individualized Education Plan (IEP)? *(¿Tiene su hijo(a) un Plan de Educación Individualizada (IEP?))*

☐ **Yes** *(Si)* ☐ **No** *(No)*

6. Does your child receive any of the following services? *(¿Recibe su hijo(a) alguno de estos servicios?)*

☐ **Childcare and Parent Services (CAPS) (child care subsidy program)**

☐ **Food Stamps** *(Cupones de Alimentos)*

☐ **SSI**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

7. Will the Pre-K center be providing transportation for your child? *(¿Recibirá su hijo(a) transporte en el Centro donde va a asistir a Pre-K?)*

☐ **Yes** *(Si)* ☐ **No** *(No)*

Parent/Guardian Signature **Date**

Parental Agreements with Child Care Facility

The _____
(Name of Facility)

agrees to provide child care for _____
(Name of Child)

on _____, beginning at _____AM
(Days of Week)

and ending at _____ PM from _____ to _____.
(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 dispensed to my child, I will provide a written authorization, which includes: Date, Name of Child, Name of Medication, Prescription Number (if any), Dosages, and Date and Time of Day to be given to child. Medicine will be in the original container with my child's name marked on it.

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

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

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

_____ 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'm not available.

I have received a copy and agree to abide by the policies and procedures for the above-named facility.

SIGNED: _____ _____
Parent/Guardian Date

SIGNED: _____ _____
Facility Administrator / Authorized Person Date

Food Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

Give Checked Medication:**
(To be determined by physician authorizing treatment)

▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪	Mouth — Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪	Skin — Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪	Gut — Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪	Throat† — Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪	Lung† — Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪	Heart† — Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪	Other† _____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give	☐ Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

BRIGHT STARS PRIMAY LEARNING ACADEMY

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Mother's Name _____

Home Phone _____ Work Phone _____

Father's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if BRIGHT STARS PRIMARY LEARNING ACADEMY cannot get in touch with me. I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

CAPS Referral for Georgia's Pre-K Program

School Year_____to _____

Families with children enrolled in a lottery-funded Georgia's Pre-K classroom who meet income and activity requirements may receive assistance with the cost of extended day services through the Childcare and Parent Services (CAPS) program. These arrangements should be made between the family and the CAPS program.

- **Families requesting assistance with child care costs** should apply online and upload this form through Georgia Gateway (www.Gateway.ga.gov).
- Families who already receive CAPS should report Pre-K as a change through Georgia Gateway (www.Gateway.ga.gov) or by contacting your Family Support Consultant at 1-833-4GA-CAPS (833-442-2277).

Family Information

Parental Authority Name: _____

Do you currently receive CAPS? Yes ☐ No ☐ If Yes, CAPS ID or Case ID: _____

Phone Number:_____ Email Address: _____

Provider Information

Georgia Pre-K Site Name: _____

Site Phone Number: _____

Site Address: _____

My child is enrolled in a Georgia's Pre-K classroom. ☐ Yes ☐ No

Child Care Provider Name (if not Pre-K Site): _____

Provider Phone Number: _____

Provider Address: _____

SAVE PRINT

#04299 – Community Childcare Food Supplement, Inc.

WIC Program Acknowledgment Form

WIC

A Special Food and Nutrition Education Program For Women, Infants and Children

WHO IS ELIGIBLE?

- A pregnant woman
- A breastfeeding woman
- A woman who has recently been pregnant
- An infant or a child less than 5 years old

SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

TO BE ELIGIBLE, YOU MUST ALSO:

- Have a low or moderate income
  AND
- Have a special need that can be helped by WIC foods and nutrition counseling

APPROVED WIC FOODS:

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.

I, _____, acknowledge receipt of the information about the WIC program. I understand that this information must be provided to every CACFP participant's family that completes an enrollment packet for the below named facility.

Center Name: _____

Director's Name: _____

Director's Signature: _____

(Please sign and return to office)

Policy Agreement

Child's Name_____
Start Date_____
Address _____
Phone # _____

Bright Stars Primary Learning Academy, Pre-K Parent Operating Handbook was created to promote an understanding of the policies and procedures at Bright Stars Primary Learning Academy, LLC. The information in the Parent Handbook applies to all Pre-K enrolled children at Bright Stars Primary Learning Academy, LLC. It is important that parents and children are familiar with these expectations.

Please be sure to read the Parent Handbook in its entirety, complete this form, and return it with the other required forms to the center. Your child will not be allowed to start at Bright Stars Primary Learning Academy, LLC without having completed and returned this form. Your signature means that you have received, read, and understand the policies and procedures of Bright Stars Primary Learning Academy, LLC.

I have read and understand the policies and procedures in the Bright Stars Primary Learning Academy, LLC Parent Handbook. I agree to abide by them as will my child(ren).

Parent Name (PRINT) _____ Date _____

Parent Signature_____

Bright Stars Primary Learning Academy, LLC

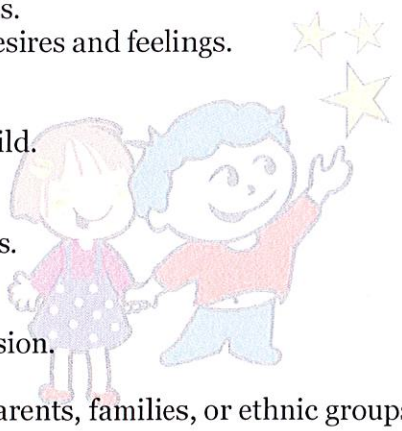
Welcome to Pre-K!

Discipline and Behavior Policy

Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, nonviolent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self-discipline. Based on this belief, Bright Stars Primary Learning Academy uses a positive approach to discipline and practices the following discipline and behavior management techniques.

WE DO

Communicate to children using positive statements on their level.
Talk with children in a calm quiet manner.
Explain unacceptable behavior to children.
Give attention to children for positive behavior.
Praise and encourage the children.
Reason with and set limits for the children.
Apply rules consistently.
Model appropriate behavior.
Provide alternatives and redirect children to acceptable activity.
Give children opportunities to make choices and solve problems.
Help children talk out problems and think of solutions.
Listen to children and respect the children's needs, desires and feelings.



WE DO NOT

Inflict corporal punishment in any manner upon a child.
Use food as a form of reward or punishment.
Use or withhold physical activity as a punishment.
Shame or punish a child if a bathroom accident occurs.
Embarrass any child in front of others.
Compare children.
Leave any child alone, unattended or without supervision.
Allow discipline of a child by other children.
Criticize, make fun of, or otherwise belittle a child's parents, families, or ethnic groups.

Conferences will be scheduled with parents if particular disciplinary/behavior problems occur. If your child's behavior consistently endangers the safety of the children around him/her, then the Director has the right, after meeting with the parents and documenting behavior problems and interventions, to terminate child care services for that particular child.
Note: If, at any point, there is an indication/suspicion that a child may have special needs, Bright Stars Primary Learning Academy will inform the child's family and make contact with Baby Babies Can't Wait or EAP for assessment and assistance.

My signature below indicates that I have received a copy of the discipline policy, it has been reviewed with me, and I have read and understand this policy.
Parent Signature_____ **Date**_____

Please circle as appropriate: PARENT, GURADIAN, and FOSTER PARENT
Name of child_____

Georgia Department of Public Health
Form 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

arent/ Guardian Name: _____
first middle last

arent/ Guardian Contact Information:

ytime phone number: _____

ening phone number: _____

ll phone number: _____

Child's Name: _____
first middle last

Date of Birth: ____/____/____ Gender: ☐Male ☐Female

Child's Home Address:

_____
street city state zip code county

VISION

☐ Unable to screen (explain why below)
☐ Uses corrective lenses
☐ Worn for testing

☐ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
☐ Needs further evaluation
☐ Under professional care (explain below)

creening completed by:
☐ Physician
☐ Local Health Department
☐ Optometrist
☐ "Prevent Blindness Georgia" employee
☐ School Registered Nurse

_____
creener's Signature **Date**
certify that this child has received the bove screening.
ontact Information:

HEARING

☐ Unable to screen (explain why below)
☐ Uses hearing aid / assistive device

☐ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
☐ Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Audiologist
☐ Speech-Language Pathologist
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

DENTAL

☐ Unable to screen (explain why below)

☐ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

NUTRITION

☐ Unable to screen (explain why below)

Height: _____ Weight: _____
BMI: _____ BMI%: _____

☐ 5th to 84th percentile - Appropriate for age
☐ < 5th percentile - Needs further evaluation
☐ ≥ 85th percentile - Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Registered Dietician
☐ School Registered Nurse

_____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

OR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
sion			
aring			
ntal			
trition			

udent support services initiated on:

Screeners' Comments:

DPH Form 3300 Rev. 2013

#04299 – Community Childcare Food Supplement, Inc.

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

Center Name: _____ **Phone#** _____ **Site#** _____

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

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

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

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

B. Other Household Members[1]. List all household members (including yourself) not listed in Part I even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often	2. Welfare, child support, alimony / How Often	3. Social Security, pensions, retirement / How Often	4. All other income / How Often
1. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____
5. _____	$_____/_____	$_____/_____	$_____/_____	$_____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Circle the meals your child will normally receive while in care: Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. If not completed fully and signed, the participant will be placed in the Paid category.

Signature: X _____ Print Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities: ☐ Asian ☐ White ☐ Black or African American ☐ Indian or Alaska Native ☐ Hawaiian or other Pacific Islander

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ Per: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Year Household Size: _____

Categorical Eligibility: check (✓) if applicable ☐ Eligibility: check (✓) one Free ☐ Reduced ☐ Paid-Denied ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow Up Official's Signature: _____ Date: _____

Community Childcare Food Supplement Inc.

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. BSPLA 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:*** BSPLA.

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals. *For more information on the Georgia's TANF and SNAP programs please call 1-877-423-4746 or visit www.gateway.ga.gov.*

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

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

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

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact BSPLA.

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.

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 770-892-9160

Sincerely,

Your Daycare Center Provider

HOUSEHOLD LETTER INSTRUCTIONS
2020-2021

Insert center name, address, and phone number in the highlighted portions of this letter.

1. Center Name: Bright Stars Primary Learning Academy

2. Center Name and Address: 8733 Tara Blvd. Jonesboro, GA 30236

3. Director/Owner's Name and Phone Number:

Jasmin Quillian / Rhonda Davis

4. Center Phone Number:

(770) 892-0160 (office) (770) 892-0161 (fax)

Please five this letter to all parents of children enrolled in your facility. All parents must sign your **Distribution Log** stating that they received a Household Letter. Please keep Distribution Logs current and file onsite. We will ask to see your Distribution Log quarterly to ensure that all items are distributed accordingly.

Georgia WIC Program

Georgia WIC
Georgia Department of Public Health
2 Peachtree Street, NW
10th Floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
Website: http://dph.georgia.gov/WIC

INCOME ELIGIBILITY GUIDELINES
(Effective from July 1, 2018 to June 30, 2019)

Household size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	22,459	1,872	936	864	432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
For each additional family member add	+ 7,992	+ 666	+ 333	+ 308	+ 154