CHILDREN'S ENROLLMENT FORM

Entrance Date_____ **Withdrawal Date**_____

Child's Name_____Sex___Age_____Date of birth_____

Home Address (Street)_____

City_____State_____Zip_____

Home Phone Number_____

Father's Name_____Home Phone Number_____

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

City_____State_____Zip_____

Father's Place of Employment _____Work Phone _____

Employer's Street Address_____City_____State_____Zip_____

Mother's Name_____Home Phone Number_____

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

City_____State_____Zip_____

Mother's Place of Employment_____Work Phone #_____

Employer's Street Address_____City_____State_____Zip_____

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

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

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

*Name_____Address_____
(Street-City-State-Zip)

Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

*Name_____Address_____
(Street-City-State-Zip)

Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

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

Name_____ Telephone Number_____

Name_____ Telephone Number_____

Name_____ Telephone Number_____

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

Child's doctor or clinic name_____

Doctor/clinic phone #_____

My child has the following special needs_____

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

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

EMERGENCY MEDICAL AUTHORIZATION

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

Parent/Guardian:_____
Signature

Date:_____

Facility Administrator/Person-In-Charge_____
Signature

Date:_____

Parental Agreements with Child Care Facility

The _____ agrees to provide child care for
(Name of Facility)
_____ on _____ _____ a.m. to _____ p.m.
(Name of Child) (Days of Week)
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; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

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

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

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

The _____ 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
_____.
(Name of Facility)

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.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Person-In-Charge)

MEDICAL INFORMATION

Doctor's Name & Phone #	Primary Health Insurance
Address	Policy Number
Dentist	
Address	
Allergies or Outstanding Health Issues	

GENERAL AUTORIZATION: I/We hereby grant to Destiny Starr Academy permission for the above named child to

c. Take part in all program activities including the use of all indoor and outdoor equipment;

d. To be photographed or videotaped in connection with daily program activities;

e. To be transported from the premises of Destiny Starr Creative Learning Academy to take part in educational field trips or activities supervised by Destiny Starr Creative Learning Academy staff (provide such field trips or activities will be separately announced to the parent or guardian 48 hours in advance of the trip or activity);

f. To be transported to and from public school – NAME OF PUBLIC SCHOOL_____

g. To participate in water activities on Destiny Starr Creative Learning Academy premises.

ENROLLMENT: Continued enrollment is not guaranteed. Destiny Starr Creative Learning Academy may determine that it is in the best interest of the child and the center to dis-enroll the child. Destiny Starr Creative Academy does not discriminate with regard to race, creed, sex, religion, national origin or disability.

SICK POLICY: This program does not provide care for sick or ill children. To avoid spreading illness to other children, PLEASE DO NOT BRING SICK CHILDREN TO THE CENTER: Children should not be brought to the center if they have or have had a fever of 100 degrees in the last 24 hours, unexplained rashes, diarrhea, vomiting, continuous non-clear discharge from the nose, yellow/green discharge from the eye, or a cough bad enough that YOU would not want your well child around a child with a cough like this.

MEDICAL AUTHORIZATION: We hereby grant to Destiny Starr Creative Learning Academy permission to take whatever action in its judgement maybe necessary in supplying emergency medical services to the above named child. We understand that, consistent with the circumstances of the situation and the available time, Destiny Starr Creative Learning Academy will attempt to contact and follow the instructions of the parent or guardian, physician or other person(s) designated above. In the event Destiny Starr Creative Learning Academy is unable to contact the parent or guardian, physician or either designated person(s) we hereby grant permission to Destiny Starr Creative Learning Academy to contact and comply with the advice of an available physician, ambulance personnel, or emergency personnel. We hereby agree that we will be solely responsible for and will promptly pay any expenses which may be incurred by Destiny Starr Creative Learning Academy in making emergency medical treatment available to the above named child.

ADMINISTRATION OF MEDICINES: The staff will administer medicine to the child upon written authorization from the parent or guardian. Written Authorization may be made by completing the "Authorization to Administer Medication Form" should be given to the Center Director. STATE LAW REQUIRES THAT ALL MEDICATION:

a. Be in it's original container
b. Be labeled with the full pharmacy label (if prescription medication)
c. Be in such condition that the name of the medication and directions for use are clearly readable on the container (if non-prescription medication)
d. Have the child's first and last name clearly on the container
e. Include directions to administer the medication (AS NEEDED IS NOT ACCEPTABLE)
f. Be administered to the child with written parental permission and as stated on the label directions or as amended by written notice of physician.

ATTENDANCE POLICY: With the exception of doctor appointments or other emergencies, Destiny Starr Creative Learning Academy reserves the right not to admit your child to the center after 9:00 a.m.

A COPY OF STATE REGULATIONS WITH RESPECT TO DESTINY STARR CREATIVE LEARNING ACADEMY IS AVAILABLE FOR REVIEW BY PARENTS. Please initial here: _____

DAYS/HOURS OF OPERATION: Destiny Starr Creative Learning Academy will operate Monday through Friday from 6:30am – 6:30pm throughout the year except; New Year's Day, Memorial Day, Independence Day, Labor Day, the day of and after Thanksgiving Day, Christmas Day and certain other days specified by Destiny Starr Creative Learning Academy from time to time. Parent will be notified at least 60 days in advance of closings other than those listed. No discount on tuition will be given for holidays or other days on which the facility does not operate.

FINANCAIL: As a participant in Destiny Starr Creative Learning Academy, you agree as follows:

A) To pay Enrollment/ Registration Fee of $75 per child at time of initial enrollment and in January each subsequent year my child/children attends

If my child is dis-enrolled for any reason and returns, the Enrollment/Registration fee will be due upon re-enrollment.

B) To pay all weekly tuition in advance of the current week. Tuition not received by 6:30p.m. on Tuesday of the current week will be charged a late penalty of $20. Delinquent accounts (more than two weeks past due) are subject to collection procedures outlined below.

C) To notify Center Director of any problems with payment of tuition as soon as possible.

D) To pay a Return Check Fee of $30 for any checks returned. Destiny Starr Creative Learning Academy will have the option to refuse future checks.

E) To pay any fees associated with the collection of my debt to Destiny Starr Creative Learning Academy including but not limited to interest of 1.5% per month, collection fees, attorney fees, court costs, etc.

INFORMATION IN THE CHILD'S FILE MUST BE KEPT CURRENT: the parent of guardian is required to furnish herein as necessary, with changes initialed and dated by parent and Center Director (or designee)/

IMMUNIZATIONS: Destiny Starr Academy strongly supports The Center for Disease Control (CDC) for children. We also follow state regulations regarding immunizations and recommend consulting your family physician for a COPY of your child's immunization record [Form 3230] is required upon enrollment. Failure to supply an enrollment and/or expiration (current) record will result in your child's disenrollment. If your child is not current on immunizations you will be charged an additional $75 registration fee. Destiny Starr Creative Learning Academy will inform you in advance of the expiration of your child's immunizations. If we fail to do so, the additional $50 fee will be waived.

DESTINY STARR CREATIVE LEARNING ACADEMY AGREES:

TO PROVIDE CARE FOR THE ABOVE NAMED CHILD MONDAY THROUGH FRIDAY (UNLESS OTHERWISE INDICATED)

DURING THE HOURS OF ____ AM - ___PM FROM _____(MONTH) TO_____(MONTH). My child will participate in the following meal plan.

_BREAKFAST _LUNCH _SNACK _DINNER

To notify parent or guardian of any incidents, including illnesses, injuries adverse reactions to medical diseases.

To create and maintain a safe, fun learning environment that addresses the needs of whole child.

To obtain written permission for all field trips and activities not covered under Article 4.

CONFIDENTIALITY: All information pertaining that child is kept on file at the center and my not be released without written permission from the parent or guardian except in the following situations"

Relevant information relating to the child's family situation, medical status and behavioral characteristics of the among caregivers on the center staff, with members of the state agency governing childcare practices, or with or the law to receive such information or with or other persons in the emergency situations involving the child.

POLICY AND PROCEDURAL CHANGES: From time to time, Destiny Starr Creative Learning Academy changes procedures. Destiny Starr Creative Learning Academy reserves the right to undertake these changes with such changes will be available for review.

I certify that I have received, read and understand the information contained in Destiny Starr Creative Learning Data Forms and agree to the terms and conditions set forth therein. I also certify that all information provided is true and correct

Signature of Parent/Guardian Date	Please Print Name

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother'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 _____
Name of Facility

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 _____

Transportation Agreement

This is to certify that I give _____
Name of Facility

Permission to transport my child _____
Name of Child

from _____ at _____ (am/pm)
Pickup Location

to _____ at _____(am/pm).
Delivery Location

My child will be transported from _____at _____(am/pm)

to _____ at _____(am/pm)
Delivery Location

on the following days:

_____ Monday
_____ Tuesday
_____ Wednesday
_____ Thursday
_____ Friday

_____ is authorized to receive my child. In the event the authorized
Name of Authorized Person

person is not present to receive my child, the following procedures are to be followed:

_____

_____

_____

The _____is approximately _____ miles from the center.
Location

In the event that my child is not to be transported as outlined above, I agree to notify the

_____.
Facility

Signature (Parent/Guardian) _____ Date _____

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file

Bright from the Start: Georgia Department of Early Care and Learning
Child and 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 FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant	Foster Child
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PART II A: A. Name (List everyone in household, including foster and non-foster children)	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
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	
1. _____	$____/____	$____/____	$____/____	$____/____	☐
2. _____	$____/____	$____/____	$____/____	$____/____	☐
3. _____	$____/____	$____/____	$____/____	$____/____	☐
4. _____	$____/____	$____/____	$____/____	$____/____	☐
5. _____	$____/____	$____/____	$____/____	$____/____	☐
6. _____	$____/____	$____/____	$____/____	$____/____	☐
7. _____	$____/____	$____/____	$____/____	$____/____	☐

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:
☐ Hispanic/ Latino
☐ Not Hispanic/ Latino

Mark one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ 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 ☐ Month ☐ Year **Household Size:** _____

Categorical Eligibility: (check if applicable) _____ **Date withdrawn:** _____ **Eligibility:** (check one) Free _____ Reduced _____ Paid _____

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

Determining Official's Signature: _____ **Date:**_____

Confirming Official's Signature: _____ **Date:**_____

Follow Up Official's Signature: _____ **Date:**_____

10/2017

Name of Sponsor (if applicable) _____

Name of Provider/Center _____

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

I will provide_____ and _____ to
Milk- based iron-fortified formula **Iron fortified infant cereal**

Infants enrolled for care in my facility.

Parents/Guardians, please check one of the following options and sign this form:

_____ I would like the provider/center to provide the milk-based iron-fortified infant formula and iron-fortified infant cereal listed above to my infant and I will provide clean, sanitized, and labeled bottles daily.

_____ I will provide_____ and
Milk- based Iron-fortified formula

_____for my infant on a daily basis.
Iron-fortified cereal

_____ _____
Parent/Guardian Signature Date

*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian although the center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

Safe Sleep Practices Policy

Child's name:_____ Date of birth:_____

Parent/Guardian name:_____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:

_____

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature_____ Date_____

Destiny Starr Academy 1850 Timothy Rd Athens, GA 30606

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Destiny Starr Academy 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: [(Name of Center, address, phone number].**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.

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

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

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

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

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

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

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 Dr. Harrison at Destiny Starr Academy.

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 706-850-8597

Sincerely,

Dr. Harrison

Dr.Harrison

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.

Building for the Future

What is CACFP?

CACFP is the Child and Adult Care Food Program, a Federal program that provides healthy meals and snacks to children and adults receiving day care.

Each day more than 2.6 million children and almost 60,000 older adults participate in CACFP. Through CACFP, participants' nutritional needs are supported on a daily basis. The program plays a vital role in improving the quality of day care and making it more affordable for many low-income families.

In addition to day care, CACFP helps make afterschool programs more appealing to at-risk youth. By offering nutritious snacks in programs serving low-income areas, centers can increase participation and know that youth are having a healthy snack.

Homeless children and children from temporarily displaced families can also receive up to three meals each day through shelters that operate the program.

Who is eligible for CACFP meals?

- children age 12 and under,
- migrant children age 15 and younger,
- functionally impaired adult participants or adults age 60 and older enrolled in an adult day care center, and
- youths through age 18 in afterschool programs in needy areas.

What kinds of meals are served?

CACFP facilities follow the meal patterns established by USDA.

- **Breakfast** consists of a serving of milk, fruit or vegetable, and grains or bread.
- **Lunch** and **dinner** require milk, grains or bread, meat or meat alternate, and two different servings of fruits or vegetables.
- **Snacks** include two different servings of the four components: milk, fruits or vegetables, grains or bread, or meat or meat alternate.

CACFP Facilities

Many different facilities operate CACFP, all sharing the common goal of bringing nutritious meals and snacks to participants.

- ***Child Care Centers***
  Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers serve meals to large numbers of children.
- ***Family Day Care Homes***
  Small groups of children receive nonresidential day care in licensed or approved private homes.
- ***Afterschool Care Programs***
  Centers in low-income areas provide free snacks to school-age children and youth.
- ***Homeless Shelters***
  Emergency shelters provide residential and food services to homeless children.
- ***Adult Day Care Centers***
  Public, private nonprofit, and some for-profit adult day care facilities provide structured, comprehensive services to functionally impaired nonresident adults.

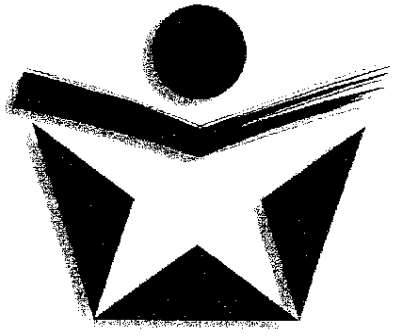
Child and Adult Care Food Program (CACFP)

How does CACFP work?

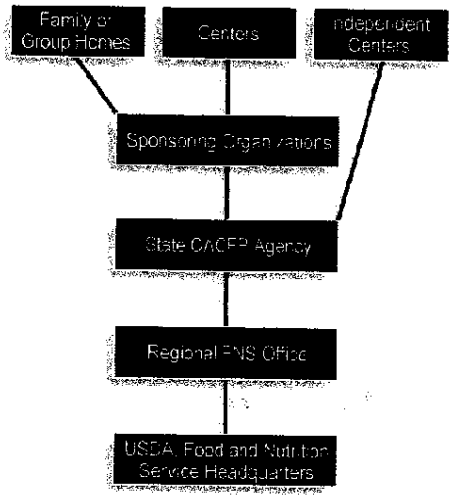
CACFP reimburses participating centers and day care homes for serving nutritious meals. It is administered at the **Federal** level by the Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA).

The **State** education or health department administers CACFP in most States. State agencies approve sponsoring organizations and independent centers to operate the program on the local level. The State also monitors the program and provides guidance and assistance to ensure requirements are met.

Sponsoring organizations play a critical role in supporting home day care providers and centers through training, technical assistance, and monitoring. All family or group day care homes must come into the program under a sponsoring organization. Several types of organizations are approved by the States to serve as sponsors—community action groups, nonprofit organizations, and churches.



CACFP Partners



Contacts

If you are interested in participating in CACFP, or have questions about the program, the sponsoring organizations and State agencies can help. Our website has State agency CACFP contact information, or call (703) 305-2620.

www.fns.usda.gov/cnd/contacts/StateDirectory.htm

USDA FNS-319 • July 2000

USDA
United States Department of Agriculture
Food and Nutrition Service

Building for the Future

in the
Child and Adult Care Food Program (CACFP)

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:

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

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

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

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

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call _____ at _____