The following documents are required for enrollment:

- Enrollment Application
- Immunization Certificate (form 3231)
- Birth Certificate
- Social Security Card
- Parent or Guardian Id.

Ms. Niecy's Learning Center Inc.

Enrollment Forms

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)_____

Parental Agreements with Child Care Facility

The _____ agrees to provide day 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 center 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)

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:_____

Ms. Niecy's Learning Center Inc.

PHOTOGRAPH / VIDEOTAPE RELEASE FORM

I hereby grant permission for Ms. Niecy's Learning Center to record the participation and appearance of my child / children.

_____ __ by photograph and/or video in connection with daily activities for the purpose of reporting, the progress of the children and the program. All information on child / children will remain on the premises and will not be shared with any other parties.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

_____

Signature (Parent / Guardian)

_____

Date

DATE: _____

HEALTH HISTORY

NAME: _____ DATE OF BIRTH: _____
NAME OF CHILDS DOCTOR: _____

BIRTH HISTORY

WHAT WAS THE LENGTH OF THIS PREGNANCY _____ MONTHS
DID YOU HAVE ANY PROBLEMS WITH THIS PREGNANCY? YES_____ NO_____
IF YES PLEASE
EXPLAIN_____

DID YOUR BABY RECEIVE OXYGEN AT BIRTH? YES_____ NO_____
TYPE OF DELIVERY, _____
BIRTH WEIGHT: _____

PAST MEDICAL HISTORY

(PLEASE CHECK ALL THAT APPLY TO YOUR CHILD)

_____NO KNOWN DISEASE PROBLEM
_____CHRONIC COLDS
_____SICKLE CELL DISEASE OR TRAITS
_____ORTHOPEDIC PROBLEMS
_____INTESTINAL PARASITES
_____MEASELS
_____IMMUNDEFICIECY DISEASE DISORDER
_____KIDNEY/BLADDER INFECTIONS OR DISEASE
___SPEECH PROBLEMS (SATE OF LAST CHECK UP)
_____DENTAL PROBLEMS (DATE OF LAST CHECK UP)

____ANEMIA
____EAR INFECTIONS
____HEAT BUMPS
____MUPS
____TONGSILITIS
____SEVERE INJURY
____HIGH FEVERS
____CHICKEN POX
____VISION PROBLEMS
____OTHERS (PLEASE EXPLAIN)

ALLERGIES

(PLEASE CHECK ALL THAT APPLIES)

_____ MILK OR MILK PRODUCTS
_____ ENVIROMENTAL COMTAMINANTS
_____FOODS (LIST)
_____ DRUGS (LIST)

CURRENT MEDICATIONS

PRESCRIPTIONS_____
OVER THE COUNTERS_____

HOSPITALISATION AND IMMUNIZATIONS

HAS YOUR CHILD BEEN HOPPITALIZED SINCE BIRTH? YES_____ NO_____
IF YES PLEASE EXPLAIN_____

ARE YOUR CHILD'S IMMUNIZATIONS UP –TO-DATE? YES_____ NO_____
DO YOU HAVE A COPY OF THE IMMUNIZATION RECORDS? YES_____ NO_____

FAMILY MEDICAL HISTORY

PARENTS (P): GRANDPARENTS (GP): BROTHER (B): SISTER (S):

NO KNOWN DISEASE OR PROBLEMS	_____P	_____GP	B_____	S
HEARING LOSS	_____P	_____GP	B_____	S
HEART DISEASE, HIGH BLOOD PRESSURE DISEASE	_____P	_____GP	B_____	S
DIABETES	_____P	_____GP	B_____	S
SICLE CELL DISESA/TRAIT/BLOOD DISORDER	_____P	_____GP	B_____	S
TB/(TUBERCOLOSIS)	_____P	_____GP	B_____	S
HEPITITUS	_____P	_____GP	B_____	S
SEZURES/IMMUNDIFICIANCY DISORDER/DISEASES	_____P	_____GP	B_____	-S
MENTAL RETARDATION/BIRTH DEFECTS	_____P	_____GP	B_____	S
	_____P	_____GP	B_____	S

Ms. Niecy's Learning Center

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 Children's at Hughes Spalding

Address 35 Jesse Hill Jr. Drive SE Atlanta, GA 30303-3032

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 _____

July 1, 2017 – June 30, 2018

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Ms. Niecy's 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 the rate for reimbursement our center will receive for feeding your child. This form will be filed and treated as **confidential information**.

Quality Care for Children (QCC) is an administrative sponsor for CACFP. QCC will help ensure our program operates and complies with USDA standards. For more information about QCC, go to www.qualitycareforchildren.org.

Frequently Asked Questions

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 main office of the child care center.** The center director will return the completed form to QCC for processing.

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 follow the instructions included with this 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 should talk to a representative at Quality Care for Children.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

Questions or Comments

Call QCC at 404-479-4255 or 404-479-4253. Monday through Friday. 8:30 am – 5:00 pm

Sincerely,

Reynaldo Green
Vice President, Health and Nutrition – Child Care Food Program

2751 Buford Highway NE • Suite 500 • Atlanta, GA 30324
Main: 404-479-4200 Fax: 404-941-2939 www.qualitycareforchildren.org

July 1, 2017 – June 30, 2018

MEAL BENEFIT INCOME ELIGIBILITY FORM

Name of Child Care Center: ______________________________

Part I. Child/Children enrolled to receive child care:

Name: (First, Middle Initial, Last)	Date of Birth (Optional) MM/DD/YY	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: Name

[illegible]

A: Name	B. Gross income and how often it was received: 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security pensions, retirement	4. All Other Income	C. Check if NO income
(Example) Jane Smith	$ 200/week	$ 150/twice a month	$ 100/month	$ /	
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 Last Four Digits of 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 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 back of this 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. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care.

Sign here: ______________________ **Print name:** ______________________ **Date:** __________

Address: ______________________ **City:** __________ **State:** ____ **Zip Code:** ______ **Phone Number:** __________

Last four digits of Social Security Number: X XX- 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:
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

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: ______________________

Temporary: Free_____ Reduced_____ Time Period: ______________________(expires after _____ days)

Determining Official's Signature: ______________________ Date: __________

Confirming Official's Signature: ______________________ Date: __________

Follow-up Official's Signature: ______________________ Date: __________

Return this completed form to the main office of the child care center.

SHARING INFORMATION WITH MEDICAID/SCHIP

Name of Child Care Center: Ms. Niecy's

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: **Quality Care for Children, Child Care Food Program, 2751 Buford Highway NE, Suite 500, Atlanta, GA 30324** right away. (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 **Quality Care for Children** at 404-479-4255 or 404-479-4253. If you wish to apply for these benefits through Medicaid or SCHIP, contact your local county DFCS office.

Return this form to the main office of the child care center.

July 1, 2017 – June 30, 2018

These are the income scales used by the United States Department of Agriculture to determine eligibility for reimbursement in the Child and Adult Care Food Program. Incomes at or below this scale are eligible for reimbursement from July 1, 2017 to June 30, 2018.

INCOME ELIGIBILITY GUIDELINES

	Reduced Price Meals – 185%			Free Meals – 130%		
Household Size	Annual Income	Monthly Income	Weekly Income	Annual Income	Monthly Income	Weekly Income
1	22,311	1,860	430	15,678	1,307	302
2	30,044	2,504	578	21,112	1,760	406
3	37,777	3,149	727	26,546	2,213	511
4	45,510	3,793	876	31,980	2,665	615
5	53,243	4,437	1,024	37,414	3,118	720
6	60,976	5,082	1,173	42,848	3,571	824
7	68,709	5,726	1,322	48,282	4,024	929
8	76,442	6,371	1,471	53,716	4,477	1,033
For each additional family member, add:	+7,733	+645	+149	+5,434	+453	+105

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 your child for free or reduced price meals. You must include the social security 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 Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child 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 your child 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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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: (202) 690-7442; or
(3) email: program.intake@usda.gov.
This institution is an equal opportunity provider.

INFANT AFFIDAVIT (MANDATORY FOR ALL INFANTS IN CARE)

In CACFP, programs must offer a USDA approved "ready-to-feed" commercially prepared iron-fortified milk-based infant formula to infants in their care. DECAL only permits these types of commercially prepared, "ready-to-feed" formula.

To be completed by center BEFORE giving to parents:

Name of Sponsor: Quality Care for Children

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, Ms. Niecy's _____ (name of center), will provide the following to infants enrolled for care in my facility:

- _____ (name of milk-based iron-fortified formula) and
- _____ (name of iron-fortified infant cereal)

Parents/Guardians:
Do not complete unless the center section above has been filled-in with both formula and cereal.

Name of Infant: _____

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 the following for my infant on a daily basis:

- _____ (name of milk-based iron-fortified formula) and
- _____ (name of iron-fortified infant 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.

Return this form to the main office of the child care center. Page 3 (Infants only)

July 1, 2017 – June 30, 2018

WIC

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

Who is Eligible?

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

Services Provided:

- Nutritious foods
- Nutrition counseling
- Healthcare 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, cereals, peanut butter, fruit or vegetables 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.

Georgia WIC Program

State WIC Office
Division of Public Health
Georgia Department of Human Services
Two Peachtree Street, NW
10th floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
http://wic.ga.gov

(Effective from July 1, 2017 to June 30, 2018)

	Reduced Price Meals – 185%				
Household Size	Annual Income	Monthly Income	Two per Month	Every Two Weeks	Weekly Income
1	22,311	1,860	930	859	430
2	30,044	2,504	1,252	1,156	578
3	37,777	3,149	1,575	1,453	727
4	45,510	3,793	1,897	1,751	876
5	53,243	4,437	2,219	2,048	1,024
6	60,976	5,082	2,541	2,346	1,173
7	68,709	5,726	2,863	2,643	1,322
8	76,442	6,371	3,186	2,941	1,471
For each additional family member, add:	+7,733	+645	+323	+298	+149

July 1, 2017 – June 30, 2018

Building for the Future

Meals

This day care facility participates in the child and Adult Care Food Program (CACFP), a federal program that provides healthy meals and snacks to enrolled participants receiving care.

Providers receive monetary reimbursement for serving nutritious meals that meet the USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snack (Two of the four groups)
Milk	Milk	Milk
Fruit or vegetables	Meat or meat alternate	Meat or meat alternate
Grains or bread	Grains or Bread	Fruit or vegetables
	Two different servings of fruits or vegetables	Grains or bread

Participating Facilities

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and for-profit centers
- **Adult Care Centers:** Public or private nonprofit and for-profits centers
- **Family Day Care Programs:** Licensed or approved private child care homes
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth
- **Emergency/Homeless Shelters:** Shelters that provide residential and food services to homeless children. Shelters are the only residential programs that may participate.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following:

- Children age 12 and under;
- Migrant children age 15 and younger
- Youths through age 18 in afterschool care programs in needy areas;
- Chronically impaired disabled adult 18 years of age or older; or
- Persons 60 years of age or older in a group setting outside their home

Contact Information

This center participates on the CACFP under the sponsoring organization listed below. The CACFP is administered in every state and in Georgia by the agency listed below. Contact one of the following for questions about the CACFP.

Sponsoring Organization:	Bright from the Start: Georgia Department of Early Care and Learning Nutrition Services
Quality Care for Children	2 Martin Luther King Jr. Drive, SE
2751 Buford Highway NE, Suite 500	Atlanta, GA 30334
Atlanta, GA 30324	404-656-5987
404-479-4251	www.decal.ga.gov
www.qualitycareforchildren.org	

This institution is an equal opportunity provider.