Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
404-696-3490
Rev. Shawn Drains, Board Chairperson
Mr. Thomas Ford, Executive Director

Welcome to the Georgia Pre-K Program here at Trinity AME Early Learning Center. Please see below, the list of required documents needed to complete the registration process.

1. Proof of Birth (Your child must be four years old on or before September 1, 2022)

- Original certified birth certificate; or child's passport. We will make copies of the original and return to you. We cannot make copies of a copy.

2. Proof of Parent/Guardian Georgia Residency

- Mortgage or lease/rental agreement in your name, OR an electric, gas, or water bill in your name. Cable and phone bills are not accepted. Bills must be dated within 30 days of your enrollment date.
- If you are living with someone and you do not have a lease, mortgage, or utility bill in your name, you must submit the following: A signed and notarized Affidavit of Residency AND a lease/mortgage statement or utility bill in the name of the person you are living with.

3. Child's Original Social Security Card

4. Please be prepared to provide a copy of your Peach Care Card, Health Insurance Card, Food Stamp Card and/or TANF. (If applicable)

5. Current Immunization Certificate (Form 3231) – We can access this for you from GRITS

6. Vision, Hearing, and Dental Screening Certificate (Form 3300)

7. CACFP Meal Benefit Income Eligibility Statement

Attached to the front of the Pre-K Application folder, you will find a list of items that are to be filled out in its entirety. Information has been provided to explain the Income Eligibility form which describes the CACFP Meal Benefit in detail. If you have any questions filling out this form, please feel free to contact the school for assistance.

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)		
Legal Last Name *(Apellido)*		
Legal First Name *(Primer Nombre)*		
Legal Middle Name *(Segundo Nombre)*		Name Suffix *(Sufijo)* (Jr,II,III)
Child's Social Security #	DOB *(Fecha de Nacimiento)* (M/D/Y)	Gender *(Sexo)*
_____ -- _____ -- _____	_____/_____/_____	☐ M ☐ F
Date enrolled in Pre-K (M/D/Y)	**If different from birth certificate, name student is called**	
_____/_____/_____		

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 siguientes 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**

GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

SIGNATURE (Parent/Guardian): _____

DATE: _____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, _____, by photograph and/or videotape in connection with daily Pre-K activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

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

PRE-K PROVIDER NAME/ADDRESS: _____

SIGNATURE (Parent/Guardian): _____

DATE: _____

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

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

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

Parent/ Guardian Name:_____
first middle last

Parent/ Guardian Contact Information:

Daytime phone number:_____

Evening phone number:_____

Cell 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)

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

_____
Screener's Signature **Date**

I certify that this child has received the above screening.

Contact 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:

FOR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
Vision			
Hearing			
Dental			
Nutrition			

Student support services initiated on:

Screeners' Comments:

Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
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Mr. Thomas Ford, Executive Director

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a childcare center. Trinity AME Early Learning Center, LLC 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 childcare. Please help us comply with the requirements of the CACFP by completing the attached CACFP Meal Benefit Income Eligibility Form also known as the Income Eligibility Statement (IES). 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 an Income Eligibility Statement (IES) for each of my children in day care?** You may complete and submit one [1] IES form for all children enrolled in childcare 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:** Trinity AME Early Learning Center, LLC, 604 Lynhurst Drive, Atlanta GA 30311 404-696-3490.
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 reduced-priced meals if your household income is within the reduced-price limits on the Federal Income Eligibility Guidelines, 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 childcare 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 Eligibility Guidelines, 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,

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Rev. Conitras M. Houston, Board Chairperson
Mr. Thomas Ford, Executive Director

put down that you get $1000 per month. If you normally receive overtime pay, include it, but not if you only work overtime on an occasional basis.

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 Income Eligibility Statement 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, regarding 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. **Will the information I give be verified?** ***(Pricing program only)*** Maybe. We may ask you to send written proof to verify the information you submitted on the form.
11. **What if I disagree with the decision about the information I complete on this form?** You should talk to your Trinity AME Early Learning Center, LLC.

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

If you have other questions or need help, call **404-696-3490.**

Sincerely,

Thomas A. Ford

Trinity AME Early Learning Center LLC
604 Lynhurst Drive SW, Atlanta, GA 30311
404-696-3490
Mr. Thomas Ford, Executive Director

Authorization to Dispense External Preparations

I give Trinity AME Early Learning Center, LLC permission to apply one or more of the following topical ointments/preparations/over the counter medications to _____ (Child's Name) 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
____ Insect Repellent
____ Non-Prescription Ointment (Such as A&D, Desitin, Vaseline)
____ Baby Powder

Other (Please Specify):
_____

Signature (Parent/Guardian): _____

Date: _____

* Trinity AME Early Learning Center, LLC will maintain a copy of this for the child's records.

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Mr. Thomas Ford, Executive Director

Parental Agreement with Trinity AME Early Learning Center, LLC

Trinity AME Early Learning Center agrees to provide care for _____ (Child's Name) on: **Monday, Tuesday, Wednesday, Thursday and Friday**. The care will be provided from _____ A.M. to _____ P.M.
My child will participate in the following meal plan:
Breakfast, Lunch, and an Afternoon Snack.

Before any medication is dispensed to my child, I will provide a written authorization which indicates: dates, name of child, name of medication, prescription number, dosages, and the time the medication should be administered. Medicine must be in the original package with your child's name 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 contact, child's physician, child's health status, infant feeding plan 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.

Trinity AME Early Learning Center, LLC agrees to obtain written authorization from me before my child participates in routine transportation for field trips/special activities that are away from the facility. Trinity AME Early Learning Center, LLC agrees to obtain written authorization for my child to participate in water-related activities occurring in water that is more than two feet deep.

I authorize Trinity AME Early Learning Center, LLC 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 Trinity AME Early Learning Center, LLC.

I understand that the facility will advise me of my child's progress and issues pertaining 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 activities at Trinity AME Early Learning Center, LLC.

Signature: _____ **Date:** _____
(Parent/Guardian)

Signature: _____ **Date:** _____
(Facility Administrator)

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Mr. Thomas Ford, Executive Director

Vehicle Emergency Medical Information

Child's Name: _____ DOB: _____

Address: _____

Father's Name: _____

Cell Phone: _____ Work Phone: _____

Mother's Name: _____

Cell Phone: _____ Work Phone: _____

Person to notify in an emergency and parents cannot be reached:
Name: _____ Phone #: _____

Child's Doctor: _____ Phone #: _____

Medical Facility: _____

Address: _____

Child's Allergies: _____

Current Prescribed Medication: _____

_____

Child's Special Needs/Conditions: _____

_____

In the event of an emergency involving my child, and if **Trinity AME Early Learning Center, LLC** cannot get in touch with me, I hereby authorize any needed 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): _____

Witnessed By: _____ Date: _____

CACFP Meal Benefit Income Eligibility Statement*

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

Name: (Last, First and Middle Initial)	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 even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. 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 ☐ Monthly ☐ Year **Household Size:** _____

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

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:** _____