Admission Information

Use this form to collect all required information about a child enrolling in day care. ***Directions:*** The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name: Kyle's Bright Beginnings Learning Center	Director's Name: Stacey Dees	
Child's Full Name:	Child's Date of Birth:	Child Lives With? ○ Both Parents ○ Mother ○ Father ○ Guardian
Child's Home Address:	Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian (if different from the child's):	

Provide contact information below where parents or guardian may be reached while child is in care.

Parent 1 Name: Email address: Phone number:	Parent 2 Name: Email address: Phone number:
Guardian Name: Email address: Phone number:	Custody Documents on File? **Yes** **No**

In case of an emergency, call:

Name of Emergency Contact:	Relationship:	Area Code and Phone No:
Address:		
I authorize the childcare operation **to release** my child to leave the childcare operation **ONLY** with the following persons. Please list the name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.		
Name:	Area Code and Phone No.:	
Name:	Area Code and Phone No.:	
Name:	Area Code and Phone No.:	

Consent Information

1. **Transportation**:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips:

☐ I give consent for my child to participate in field trips. ☐ I DO NOT give consent for my child to participate in field trips.

Additional Comment:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ **water table play** ☐ **sprinkler play** ☐ **splashing or wading pools** ☐ **swimming pools** ☐ **aquatic playgrounds**

Is your child able to swim without assistance? ☐ YES ☐NO If NO, what type of assistance is needed?

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for: (Check all that apply)

☐Discipline and Guidance	☐Procedures for release of children
☐Suspension and expulsion	☐Illness and exclusion criteria
☐Emergency plans	☐Procedures for dispensing medications
☐Procedures for conducting health checks	☐Immunization requirements for children
☐Safe sleep	☐Meals and food service practices
☐Procedures for parents to discuss concerns with the director	☐Procedures to visit the center without securing prior approval
☐Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions	☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website
☐Procedures for parents to participate in operation activities	☐ Procedures for supporting inclusive services

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐Supper ☐ Evening snack

6. Days and Times in Care:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

My child is normally in care on the following days and times:

Child's Special Care Needs (check all that apply)

☐ Environmental allergies	☐ Limitations or restrictions on child's activities
☐ Food intolerances	☐ Reasonable accommodations or modifications
☐ Existing illness	☐ Adaptive equipment *(include instructions below)*
☐ Previous serious illness	☐ Symptoms or indications of complications
☐ Injuries and hospitalizations (*past 12 months*)	☐ Medications prescribed for continuous long-term use

☐ Other:

Explain any needs selected above:

Does your child have diagnosed food allergies? ☐ Yes ☐ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the **Americans with Disabilities Act (ADA), Title 111**. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title 111, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature of Parent / Legal Guardian: _____ Date :_____

Signature of Center Designee: _____ Date : _____

School Age Children

My child attends the following school:

School Area Code and phone No.:

My child has permission to (check all that apply) :

☐ Walk to or from school ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician: Address Phone number:

Name of Emergency Care Facility: Address Phone number:

I give consent for the facility to secure all necessary emergency medical care for my child.

_____ _____

Signature – Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ **Left Eye 20/** ☐ **Pass** ☐ **Fail**

_____ _____

Signature **Date Signed**

Hearing Exam Results

Ear	1000Hz	2000 Hz	4000Hz	Pass or Fail
Right				☐ Pass ☐ Fail
Left				☐ Pass ☐ Fail

_____ _____

Signature **Date Signed**

Admission Requirement

If your child does not attend pre-kindergarten or school away from the childcare operation, one of the following must be presented when your child is admitted to the childcare operation or within one week of admission. (Select only one option below.)

☐ Health Care Professional's Statement: I have examined the above names child within the past year and find that he or she is able to take part in the day care program.

☐ A signed and dated copy of a health care professional's statement is attached.

☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the childcare program operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

_____ _____

Signature – Health Care Professional **Date Signed**

_____ _____

Signature – Parent or Legal Guardian **Date Signed**

Vaccine Information		
The following vaccines require multiple doses over time. Please provide the date your child received each dose.		
Vaccine	**Vaccine Schedule**	**Dates Child Received Vaccine**
Hepatitis B	Birth (1st dose)	
	1-2 months (2nd dose)	
	6-18 months (3rd dose)	
Rotavirus	2 months (1st dose)	
	4 months (2nd dose)	
	6 months (3rd dose)	
Diphtheria, Tetanus, Pertussis	2 months (1st dose)	
	4 months (2nd dose)	
	6 months (3rd dose)	
	15-18 months (4th dose)	
	4-6 years (5th dose)	
Haemophilus Influenza Type B	2 months (1st dose)	
	4 months (2nd dose)	
	6months (3rd dose)	
	12-15 months (4th dose)	
Pneumococcal	2 months (1st dose)	
	4 months (2nd dose)	
	6 months (3rd dose)	
	12-15 months (4th dose)	
Inactivated Poliovirus	2 months (1st dose)	
	4 months (2nd dose)	
	6-18 months (3rd dose)	
	4-6 years (4th dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12-15 months (1st dose)	
	4-6 years (2nd dose)	
Varicella	12-15 months (1st dose)	
	4-6 years (2nd dose)	
Hepatitis A	12-23 months (1st dose)	
	The 2nd dose should be given 6 – 18 months after the 1st dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement. My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature _____ **Date signed:** _____

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm

TB Test (If Required)

☐ **Positive** ☐ **Negative** **Date :** _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a childcare center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health professional verifying immunization information above.

Signature: _____ **Date Signed:** _____

Signatures

Child's Parent or Legal Guardian : _____ **Date Signed:** _____

Center Designee: _____ **Date Signed:** _____

CONSENT TO VIDEO/PHOTOGRAPH RELEASE for KBB Promotional Website and Social Media

I understand that my child's voice, physical presence, and participation in classroom activities may be photographed and/or video recorded will not be a violation of his/her personal rights. I hereby release any claims for such use during the duration of his/her enrollment at Kyle's Bright Beginnings Learning Center.	**___I DO give my consent.** **___ I DO NOT give my consent.** **Student's Name: _____**

Signature of Parent/ Guardian: _____ Date Signed: _____

TUITION POLICY AGREEMENT

I understand that tuition is due on Friday prior to the week of service, or period of service. I understand that any appropriate tuition and/or fees will be invoiced to my brightwheel account and automatically paid through the Auto-pay function in brightwheel, which is required. I will link either a Credit Card, Debit Card, or Bank Account to my brightwheel account and make sure that there are adequate funds available to pay the tuition/fees when due. If any payments are returned I will have until the next business day to necessary adjustments to have the tuition/fees amount ready for Auto-pay withdrawal. If not corrected, I understand that a $35.00 Return Payment fee will be added to my brightwheel account. If not corrected within 3 business days, my child will not be allowed to attend until tuition is paid. After five days of delinquency, my child will be withdrawn from KBB.

If there is a valid reason AutoPay cannot be used for tuition payment, an alternative payment method can be arranged with prior mutual agreement between me and KBB management.

I understand that any amount owed to KBB will be subject to legal collection proceedings through civil or criminal court as appropriate and I will be responsible for any collection costs incurred.

Parent /Guardian Signature: _____ Date: _____

LATE PICK-UP CHARGES
Late pick-up fees are **$15.00** for anytime between 6:30 pm and 6:35 pm per child**, PLUS $1.00** for every minute thereafter per child.

VACATION DISCOUNT
Vacation discounts are allowed twice per year. I acknowledge that I have two (2) weeks of vacation absences per year per KBB's Vacation Request Guidelines below:

1. Submit a written notice of request for any given week (Monday – Friday) at least two weeks prior to vacation request period.
2. Pay a $100.00 administrative fee with the written request notice.
3. I acknowledge that when using a vacation week, my child WILL NOT be in the care of KBB for the entire week.

Parent /Guardian Signature: _____ Date: _____

TEXAS Health and Human Services

Form 2987
October 2023

Parent's Rights

This form provides the required information per Chapter 42 of the Human Resource Code (HRC) Section 42.04271.

Directions: Parents will review these rights upon enrolling their child.

Rights of Parent or Guardian

A parent or guardian of a child at a child care facility has the right to:

(1) enter and examine the child care facility during the facility's hours of operation without advanced notice;

(2) review the child care facility's publicly accessible records;

(3) receive inspection reports for the child care facility and information about how to access the facility's online compliance history;

(4) obtain a copy of the child care facility's policies and procedures;

(5) review, at the request of the parent or guardian, the facility's:

(A) staff training records; and

(B) any in-house staff training curriculum used by the facility;

(6) review the child care facility's written records concerning the parent's or guardian's child;

(7) inspect any video recordings of an alleged incident of abuse or neglect involving the parent's or guardian's child, provided that:

(A) video recordings of the alleged incident are available;

(B) the parent or guardian of the child does not retain any part of the video recording depicting a child that is not their own; and

(C) the parent or guardian of any other child captured in the video recording receives written notice from the facility before allowing a parent to inspect a recording;

(8) have the child care facility comply with a court order preventing another parent or guardian from visiting or removing the parent's or guardian's child;

(9) be provided the contact information for the child care facility's local Child Care Regulation office;

(10) file a complaint against the child care facility by contacting the local Child Care Regulation office; and

(11) be free from any retaliatory action by the child care facility for exercising any of the parent's or guardian's rights.

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signature of Parent or Guardian **Date**

Resources

Facility Information and Online Compliance History: http://txchildcaresearch.org

Child Care Regulation Contact Information: https://www.hhs.texas.gov/services/safety/child-care/contact-child-care-regulation

CACFP Food Program Enrollment Form

Center Name:
Phone Number:

Child 1

1 – Child's Name:

2 – Date of Birth:

3 – Enrollment Date:

4 – Days in Care: ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ Saturday ☐ Sunday

5 – Start Time in Care: ☐ AM ☐ PM

6 – End Time in Care: ☐ AM ☐ PM

7 – Meals Served to Child While in Care:

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ EV Snack

8A – Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

8B – Race

☐ White ☐ African American ☐ Asian ☐ American Indian or Alaskan ☐ Hawaiian or Pacific Islander

(For Office Use Only) **Withdrawal Date:**

Child 2

1 – Child's Name:

2 – Date of Birth:

3 – Enrollment Date:

4 – Days in Care: ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ Saturday ☐ Sunday

5 – Start Time in Care: ☐ AM ☐ PM

6 – End Time in Care: ☐ AM ☐ PM

7 – Meals Served to Child While in Care:

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ EV Snack

8A – Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

8B – Race

☐ White ☐ African American ☐ Asian ☐ American Indian or Alaskan ☐ Hawaiian or Pacific Islander

(For Office Use Only) **Withdrawal Date:**

Child 3

1 – Child's Name:

2 – Date of Birth:

3 – Enrollment Date:

4 – Days in Care: ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ Saturday ☐ Sunday

5 – Start Time in Care: ☐ AM ☐ PM

6 – End Time in Care: ☐ AM ☐ PM

7 – Meals Served to Child While in Care:

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ EV Snack

8A – Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

8B – Race

☐ White ☐ African American ☐ Asian ☐ American Indian or Alaskan ☐ Hawaiian or Pacific Islander

(For Office Use Only) **Withdrawal Date:**

Child 4

1 – Child's Name:

2 – Date of Birth:

3 – Enrollment Date:

4 – Days in Care: ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ Saturday ☐ Sunday

5 – Start Time in Care: ☐ AM ☐ PM

6 – End Time in Care: ☐ AM ☐ PM

7 – Meals Served to Child While in Care:

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ EV Snack

8A – Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

8B – Race

☐ White ☐ African American ☐ Asian ☐ American Indian or Alaskan ☐ Hawaiian or Pacific Islander

(For Office Use Only) **Withdrawal Date:**

By signing this form, I acknowledge that I have received the enrollment and income form for the CACFP, as well all supplemental information, including Form 1625A, Letter to Households, Building for the Future and WIC flyers.

Did you complete **all 8 required fields** for **each child enrolled**?

9 – Signature – Parent or Guardian

10 – Date of Signature

Parent/Guardian Email Address

Parent/Guardian Phone No.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660),* provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 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 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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

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: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

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 the participant for free or reduced price meals. You must include the last four digits of the Social Security Number 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 Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant 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 the participant 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. This center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Meal Benefit Form for each of my children in day care?** *You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household* ***only*** *if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information.* ***Return the completed form to our day care center.***

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) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.*

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 Income Chart, sent with 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 can provide the Texas Department of Family and Protective Services Form 2085FC, Placement Authorization Foster Care/Residential Care, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility 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 can talk to our center's director, either in person or by telephone. You may ask for a hearing by calling or writing to our day care facility.*

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 our facility at the number listed on your enrollment form.

Texas Department of Agriculture

Form H1625-A
March 2024

Income Eligibility Guidelines for Determining Free or Reduced-Price Benefits July 1, 2024 – June 30, 2025

Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.

Ingresos máximos para determiner la elegibilidad para beneficios gratuitos o a precio reducido 1 de julio de 2024 - 30 de junio de 2025

Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

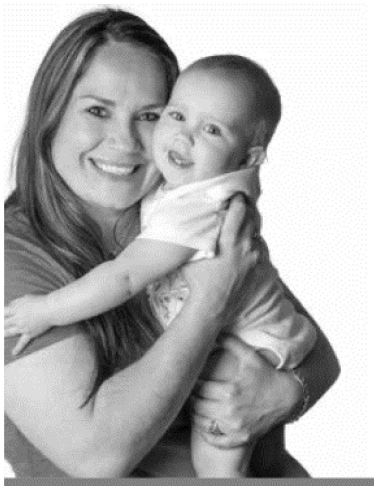
FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	$27,861	$2,322	$1,161	$1,072	$536
2	$37,814	$3,152	$1,576	$1,455	$728
3	$47,767	$3,981	$1,991	$1,838	$919
4	$57,720	$4,810	$2,405	$2,220	$1,110
5	$67,673	$5,640	$2,820	$2,603	$1,302
6	$77,626	$6,469	$3,235	$2,986	$1,493
7	$87,579	$7,299	$3,650	$3,369	$1,685
8	$97,532	$8,128	$4,064	$3,752	$1,876
For each additional family member add:	$9,953	+$830	+$415	+$383	+$192

Join Texas WIC

We're here for you

"Thanks to WIC, I now have the tools I need to make sure my family stays on the path to a healthy lifestyle."

—Roxie, WIC Client



As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	$ 3,152	$ 37,814
3	$ 3,981	$ 47,767
4	$ 4,810	$ 57,720
5	$ 5,640	$ 67,673
6	$ 6,469	$ 77,626

Effective April 1, 2024

* A pregnant woman's household can be increased by the number of infants she is expecting. For more than 6 household members, call your local WIC office.
** Income can also be determined on a weekly or biweekly basis.

Start now. Call 1-800-942-3678 or visit TexasWIC.org

TEXAS Health and Human Services | TEXAS WIC

This institution is an equal opportunity provider.

This child care receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program.

Questions? Concerns?

Call USDA at 1-866-873-2263

OR

Food and Nutrition Division at 1-800-TELL-TDA (835-5832)

Your child care at Coastal Child Nutrition Services

Contact Information: CACFP Sponsor
Address: 1607 S. Chestnut St. Suite M, Lufkin, TX 75901
Phone Number: (888) 887-3804
Email Address: ccns@mycacfp.com
Other Necessary Information: www.mycacfp.com

TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

Fraud Hotline: 1-866-5-FRAUD-4 or 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711
Tdl Free: (877) TEX-MEAL | For the hearing impaired: (800) 735-2989 (TTY)

Food and Nutrition Division
Child and Adult Care Food Program

This product was funded by USDA.
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Updated 11/17/2021
www.SquareMeals.org