Enrollment Application

www.cobbcare.com

Child's Information

Rates Cover 10 Hours of Care

Hours Of Care ___AM - ___PM

Note: This application must be completely filled out. If information does not apply, the blank should be noted with a N/A, otherwise, it should be completed. **591-1-1-.08 (a)**

Child's Name: _____Enrollment Date _____ Withdrawal Date _____

First _____ Middle _____ Last _____

Home Address _____

Birth Date _____ Age _____ Sex _____ Grade (if applicable) _____

Parent/Guardian Information 591-1-1-.08 (b)

*Note: This Entire Section is required. Simply place N/A in fields that do not apply to you.

Child lives with ☐ Mother ☐ Father ☐ Mother & Father ☐ Guardian _____

Who is the custodial parent of the child? _____

Mother/Guardian: (First) _____ MI _____ (Last) _____D.O.B _____

Home Address _____ City _____ GA Zip _____

Employer _____ Supervisor's Name _____

Work Address _____

Work Phone _____ Home Phone _____ Cell Phone _____

Email Address _____ Preferred Method of Contact: _____

☐ The mother of this child is not actively in this child's life and/or no information is available. This parent may not visit or checkout the child without prior approval from the custodial parent.

Father/Guardian: (First) _____ MI _____ (Last) _____ D.O.B._____

Home Address _____ City _____ GA Zip _____

Employer _____ Supervisor's Name _____

Work Address _____

Work Phone _____ Home Phone _____ Cell Phone _____

Email Address _____ Preferred Method of Contact: _____

☐ The father of this child is not actively in this child's life and/or no information is available. This parent may not visit or checkout the child without prior approval from the custodial parent.

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Authorized Contacts to Pick-up/Drop-Off My Child

As an authorized parent/guardian of the child enrolled in this Enrollment Application, authorization is hereby granted for this child to be dropped off and/or released to the authorized and emergency contacts listed below. It is understood that legal authorities will be contacted to pickup my child if he/she is left at Show Me Love Learning Academy Inc. one hour after closing time. **591-1-1.08 (c) (d); 591-1-1-.23 (f)**

Name	Address & City/State/Zip	Home Phone	Work Phone	Relationship to Parent/Guardian	Relationship to Child

Medical **Please select your child's Primary Physician** 591-1-1.08 (e) (f)

Please mark an "**X**" next to your child's Physician or write in his/her name below.

OTHER:

Physician Name _____ Address _____ Phone _____

Medical Insurance Company _____ Member ID# _____ Group # _____

Authorization to Obtain Emergency Medical Care: 591-1-1.23(a). I/We agree that the staff of Show Me Love Learning Academy Inc. may authorize the physician of their choice to provide emergency treatment in the event that neither the family physician nor I can be contacted immediately. SMLLA agrees to secure appropriate emergency transportation to Well Star Cobb in the event of an emergency. In an emergency situation, a responsible adult will supervise and accompany the child to WSC while transported to WSC in the event of the absence of the parent/guardian. We will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian or full time custodian. The parent/guardian agrees to be responsible for all fees incurred to secure emergency medical care for their child.

Signature _____ **Date** _____ **20**____

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Authorization to Administer Medication: 591-1-1.23 (b). I understand that NO medication will be administered to any child without a Medication Authorization Form being completed and filed with the office. All medications administered will be documented along with any noticeable adverse reactions. If severe, or mild adverse reactions are noticed, the parent(s) will be notified. All medication must be given to the Director, Assistant Director, or person in charge with a completed Authorization to Administer Medication Form**. No medicine should ever be given to anyone without a completed medication form.** Medication must be delivered in the original container with the instructions as prescribed by the doctor listed on the container. Each day the parent must document the date and time that medication was last administered at home. **SMLLA will NOT administer any medication prescribed to be given more than once a day.** No medication will be administered for longer than two (2) weeks without a written authorization from a physician.

Signature _____

Is your child Asthmatic _____ **Does he/she take breathing treatments** _____

If yes, How often are breathing treatments given? _____

Will we need to give your child breathing treatments? If so, how often? _____

REQUIREMENT: Children receiving breathing treatments and/or medication on a regular basis must have written authorization from their physician.
Signature_____ **Date** _____

591-1-08.(f) Please answer Yes, NO, or NA to the following questions. Explain as necessary.

YES or NO	Enrollment Questionnaire
Select One	Any Existing Illness? If yes Explain:
Select One	Previous Serious Illness? If yes Explain:
Select One	Hospitalized Last 12 Months? If yes Explain:
Select One	Special Diet? If yes Explain:
Select One	Allergies? If Yes Please List and Complete the Allergy Action Plan for each Allergy:
Select One	Physical Challenges, Mental Health Disorders, Mental Retardation, Developmental Disabilities? If yes Explain:
Select One	Has your child received or currently receive services outside of school? If yes Explain:
Select One	Was there any difficulty at birth? If yes Explain:
Select One	Does your child move up and down climbing equipment independently?
Select One	Does your child speak in words? Age your child began talking _____
Select One	Does your child speak in sentences?
Select One	Has your child ever been referred to Babies Can't Wait?
Select One	Does your child have any language difficulties? If yes Explain?
Select One	Can your child indicate his/her own bathroom needs?
Select One	Has your child ever been evaluated for any developmental needs? If yes Explain:
Select One	Has your child completed Toilet Training?
Select One	Is Potty Training in Progress? **Or N/A**
Select One	Has your child had any group play experience? **If yes, Where?**

What behavior do you correct most often? _____

How do you correct your child's inappropriate behavior? _____

How well does your child respond to discipline _____

Please add anything else you think we should know about your child _____

_____

Child's Previous preschool experience (if any): _____

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Is your child Right or Left Handed? _____ **Does the child have any special problems-fears?** _____

Does child wear glasses? _____ **Does child wear a hearing aid?** _____

Please Explain special procedures required to be followed in caring for your child, including any special services that may be within the service parameters of SMLLA's scope of services; 591-1-1-.08(h)

_____

_____

Authorization for Child to Participate in Field Trip and Water Related Activities: 591-1-1-.23(c)(d) ***Please Initial*** - I/We do _____ do not _____ give my permission for my child to participate in fieldtrips away from the center, water related activities of 2 feet or more water and special activities away from the school. I understand that I will be notified in advance of any instances in which my child will be taken from the school, including the date, destination, and method of transportation of such trip. In addition, I understand that I will be required to provide written authorization for each field trip/activity away from the school.

Authorization for Child to Take Pictures. ***Please Initial*** **–** I/We do _____ I/We do not _____ give permission for my child to take pictures, participate in video recordings that all may be utilized in advertisements and website developments with no requirement for compensation.

I/ We acknowledge it is my/our responsibility to keep my/our child's records current to reflect any significant changes as they may occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans, and immunization records, etc. **591-1-1-.08(k)**

I/We acknowledge that all persons authorized to pick up or drop off my/our child at SMLLA (including us), will not allow my/our child to enter or leave the center without being escorted and that the center will not permit the child to enter or exit the center without an escort. Failure to adhere to this regulation may result in **immediate termination. 591-1-1.08(l)**

I/We acknowledge that I/we understand and agree that our account will be charged an early drop off fee of $20 if my /our child is not clocked/signed in daily and a $20 late pickup fee if my/our child is not signed/clocked out daily. Daily arrival and departure records are required by the **Georgia Department of Early Care and Learning**. My/Our failure to properly document daily arrival and departure times will seriously impact the status of SMLLA's compliance with state regulations. Therefore, I/we agree that my/our child can be terminated for this cause. Our responsibility for outstanding fees and fees for the two-week notification period will continue to be due and payable. I/We will assume all responsibility for legal fees incurred as a result of this termination.

Each family is assigned a **Personal Identification Code (PIN)** to electronic clock the child into and out of the center. This code should never be shared. All individuals authorized to drop off or pickup my/our child will be advised to stop at the Main Office to be assigned a PIN. During the first visit, picture identification must be provided before a PIN may be assigned. I/We understand that my/our child **will** be terminated if it is determined that I/we have shared our PIN number for my/our child's drop off or pickup.

I/We acknowledge receipt of a **SMLLA** Parent Handbook. I/We accept responsibility for reading and adhering to the regulations that govern the operations of the center. Regulations may be changed from time to time. However, any change to the regulations of the Parent Handbook will be reduced to writing In the school's monthly newsletter. Each parent accepts responsibility for getting a copy of the monthly newsletter from the Academy's Web Page. No regulation can be verbally altered.

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.

I/We understand that I/we must inform SMLLA in writing 2 weeks in advance if I/we plan dis-enroll our child(ren). I/We understand that the Full Weekly Tuition is Due whether the child(ren) are in attendance or not.

591-1-1-.08(n) Information pertaining to the children enrolled in SMLLA is considered confidential and will not be released by center staff without first obtaining **written** permission signed by the parents or guardians, except in the following situations:

a) Relevant Information relating to the children's family situations,
b) Medical status and behavioral characteristics on the children enrolled at SMLLA may be shared **at anytime** among **caregivers** of SMLLA, members of DECAL, and other persons authorizes by these rules
c) The law to receive such information, or
d) With other persons in an emergency situation involving the child.

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Enrollment Application

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Infant & Toddlers

Please complete the following section if your child is currently 24 months or younger.

Does your child…. (Please Answer Yes, No, or N/A)

YES, NO, or N/A	Questionnaire
N/A	Drink Whole Milk?
N/A	Use Bottle?
N/A	Use a Sippy Cup?
N/A	Use a Regular Cup?
N/A	Currently drink Formula? If yes, what kind? _____
N/A	Have a Favorite Food? If yes, what kind? _____
N/A	Have a Favorite Toy? If yes, what kind? _____
N/A	Attended a Preschool? If yes, where? _____
N/A	Take Regular Naps? If yes, what is the usual time? _____

I understand that my child will be served breakfast, lunch, afternoon snack and Dinner.

Contact Information

Director:	**Mrs. Kymberlee Peeks**	**770*944*9100**
Asst. Director:	**Mr. William Alford**	**770*944*9100**
Address:	**1221 Old Powder Springs Rd. Mableton GA. 30126**	
Email:	**showmeloveenrollment@gmail.com**	
Website:	**www.cobbcare.com**	

Show Me Love Learning Academy enrolls children of any race, color, sex, and national or ethnic origin, to all the rights, privileges, programs, and activities generally accorded or made available to children at the school. We do not discriminate on the basis of race, color, sex, or national or ethnic origin in administration of its educational policies, admissions policies, scholarship programs, and other school-administered programs.

If only one signature applies to you, simply sign your name on all the required signature fields.

Mother's Signature _____ Date _____

Father's Signature _____ Date _____

Guardian's Signature _____ Date _____

SMLLA's Signature *Kymberlee Alford* Owner/Director _____ Date _____

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Bright from the Start: Georgia Department of Early Care and Learning
Child and Adult Care Food Program
Income Eligibility Statement

Center Name:Show Me Love Childcare

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

Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant	Foster Child
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PART II A: A. Name (List everyone in household, including foster and non-foster children)	B. Gross income and how often it is received. Example: $100/Monthly, $100/twice a month, $100/every other week, $100/weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	
1.	$ ____/____	$ ____/____	$ ____/____	$ ____/____	☐
2.	$ ____/____	$ ____/____	$ ____/____	$ ____/____	☐
3.	$ ____/____	$ ____/____	$ ____/____	$ ____/____	☐
4.	$ ____/____	$ ____/____	$ ____/____	$ ____/____	☐
5.	$ ____/____	$ ____/____	$ ____/____	$ ____/____	☐
6.	$ ____/____	$ ____/____	$ ____/____	$ ____/____	☐
7.	$ ____/____	$ ____/____	$ ____/____	$ ____/____	☐

PART III: ENROLLMENT INFORMATION: ***Children Only***

My child is normally in attendance at the facility between the hours of _____ ☐ [am / ☐ pm] to _____ ☐ [am / ☐ pm] on the following days:

☐ Check here if only before/after school care is provided

(Check all that apply): ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

My child will normally receive the following meals while in care:

(Check all that apply): ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

PART IV: Signature and Social Security Number (Adult MUST sign).

An adult household member must sign this form. If Part II is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care.*

Signature: X _____ **Print Name** _____ **Date** _____

Address: _____ **City** _____ **State:** GA **Zip** _____ **Phone** _____

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

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander

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

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

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

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

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

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

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

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly Income
1	$22,311
2	$30,044
3	$37,777
4	$45,510
5	$53,243
6	$60,976
7	$68,709
8	$76,442
Each additional person	Add: $7,733

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 mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov.

This institution is an equal opportunity provider.

INSTRUCTIONS

Households that receive Food Stamps, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number.
Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children.
Part II: Skip this part.
Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: Sign the form. A Social Security Number is not necessary.
Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home, child care center or adult day care, list participant's name.
Part II: To report total household income from last month, complete the following:
Column A-Name: List the first and last name of each person living in your household as an economic unit. You must indicate yourself and all children living with you (including foster and non-foster children). In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Attach another sheet if necessary.
Column B-Gross Income last month and how often it was received: Next to each person's name, list each type of income received last month, and how often it was received.
Box 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
Box 2: List the amount each person got last month from welfare, child support, alimony.
Box 3: List Social Security, pensions, and retirement.
Box 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
Column C-Check if no income: If the person does not have any income, check the box.
Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: An adult household member must sign the form, and list the last four digits of his/her social security number. Or, mark the box if he/she does not have one.
Part V: Answer this question if you choose to.

Privacy Act Statement: This explains how we use the information you give us.

The Child and Adult Care Food Program

Income Eligibility Statement Form and Supporting Documents

The United States Department of Agriculture (USDA) issued revised Income Eligibility Statements (IES) and other required forms to all state agencies to disseminate to institutions participating in the Child and Adult Care Food Program (CACFP). The newly revised IES package includes the following: IES form and instructions, reduced income guidelines template with privacy and non-discrimination statement, Sharing Information with Medicaid/SCHIP letter, sample house-hold letters based on program type, and template letters to use when verifying income and reporting the results of the verification.

The revised IES package and supporting documents is available at http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP.

Frequently Asked Questions

Q. What information do I issue to parents?

A. Institutions and facilities should issue the IES form, reduced income guidelines with the privacy and non-discrimination statement, appropriate household letter, and the Sharing Information with Medicaid/SCHIP letter to parents/guardians of children/adults participating in the CACFP.

Q. Can centers/day care homes require parents/guardians to complete the IES form as part of the enrollment package?

A. Centers/day care homes can **request** that parents/guardians complete the form as part of the enrollment process, but centers should **not require** parents/guardians to complete the form nor should they have policies/practices in place that negatively impacts the prospective/current participant's enrollment if the parent declines or fails to complete or submit the form. This action would be in violation of the Program.

Q. Why is it necessary to issue the Sharing Information with Medicaid/SCHIP letter to parents?

A. Parents/guardians that do not wish to have their information shared with either Medicaid or SCHIP must complete the form and return to facility. Otherwise and when requested by Bright from the Start or the United States Department of Agriculture (USDA), parent/guardian information will be shared with Medicaid/SCHIP.

Q. Is it necessary to have three official's signatures on the new IES form-especially when the center is an independent center with only one staff person managing the CACFP?

A. No. Only one signature is required for Independent centers with only one staff person responsible for managing the CACFP. However, institutions with more than one person managing the CACFP, and center and administrative sponsors are required to have a minimum of two signatures: determining official and confirming official.

Q. What is the purpose of having a determining and confirming official signature?

A. The confirming official will review the form and ensure accuracy and completeness. IES forms are considered current and valid until the last day of the month in which the form was dated on year earlier. The date to be used to make this determination is the date in which the sponsor or institution official signs the IES form to certify eligibility of the participant.

Q. How long is the IES form considered current and valid?

A. IES forms are considered current and valid until the last day of the month in which the form was dated one year previously. The date used to make this determination is the date in which the sponsor/ independent center official or parent/guardian signs the IES form. CACFP institutions and SFSP sponsors must decide which date they will use as the effective date and apply this date to all income eligibility forms submitted on behalf of all participants. CACFP institutions and SFSP sponsors are required to complete the **Income Eligibility - Effective Date Option Form.** In addition, institutions must indicate the options chosen in Section VIII. Recordkeeping (Item #2) of their Management Plan. This means that sponsor and independent center officials should not request parent/guardians to complete IES forms at a specific frequency (e.g. start of each school year, every June, etc.). Request made by the sponsor or independent center official for IES form completion should be based solely on the expiration date of the IES forms.

Q. Do I send a report to Bright from the Start listing parent/guardians that want their information shared with Medicaid/SCHIP?

A. No. When instructed by USDA, Bright from the Start will request and collect data from institutions.

Q. Can this form be used for children in childcare facilities and adults in adult daycare facilities?

A. Yes.

Q. Can siblings be listed on one form?

A. Yes. Siblings from the same household can be listed on one form as long as there is space available.

Q. When do I verify parent/guardian income?

A. At the request of the United States Department of Agriculture (USDA), Bright from the Start, or any of its agents.

Q. Where can I get copies of the IES form and supporting documents?

A. Access Bright from the Start's webpage at
http://www.decal.ga.gov/BftS/FormList.aspx?cat=CACFP

Q. Can I still participate in the CACFP if parents do not complete the IES form or do not return the form to my center?

A. Yes. However, children that do not have IES forms on file must be placed in the "**paid**" category on the roster, which will effect monthly reimbursement. Centers that are using the IES form to capture annual enrollment information will be required to use an alternate enrollment form that captures at a minimum the name of the child, normal hours and days of care and meals the child usually receives while in attendance.

Q. What if the form is completed by the parent but is not signed and dated by the sponsor or independent official. Is the form valid?

A. The form would neither be current nor valid for free or reduced price meals since the signature and date of the sponsor or independent official is the certification of the eligibility of the participant.

Q. Are households required to report changes in circumstances?

A. No, Public Law 108-265 modified the requirements related to reporting changes in income during the period of eligibility covered by the application. Households are not required to report changes in circumstances, such as increase in income, a decrease in household size, or when the household is no longer certified eligible for benefits through Supplemental Nutrition Assistance Programs (SNAP) or Temporary Assistance for Needy Families (TANF).

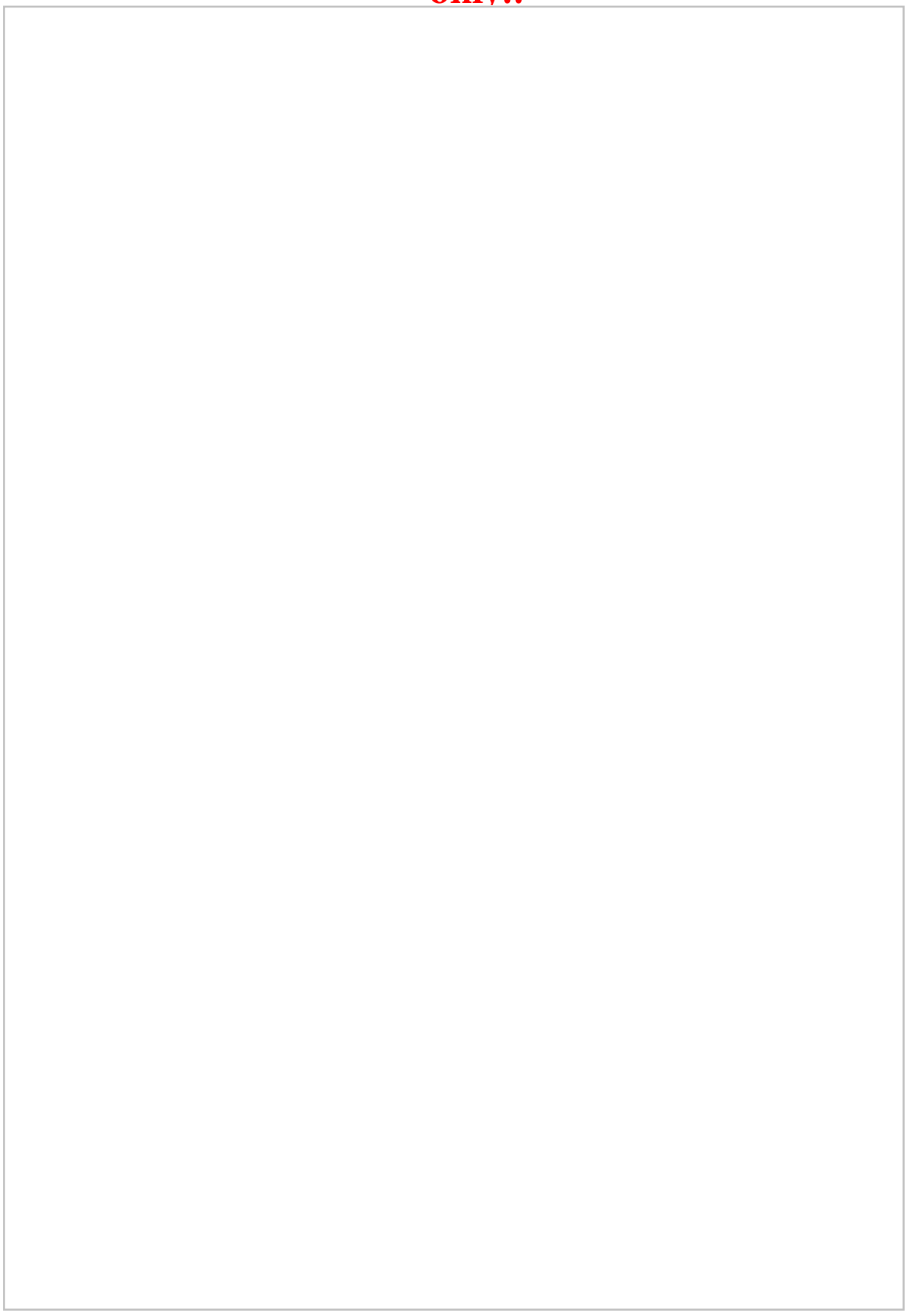
Q. Are temporary approvals (45 days) still required when no income is reported?

A. No. Temporary approvals previously provided for short term assistance, such as when a household experienced a temporary income reduction or when no income was reported have been eliminated, are no longer required. Now, year-long eligibility includes households that report no income on their IES forms.

Q. Can parents list some but not all of the household income received?

A. No, the IES form requests all the household income including the frequency. By signing the IES form the parent/guardian certifies that all the information on the form is true and that all income is reported and that they understand that the center or day care home will receive Federal funds based on the information listed by the parent/guardian.

Please click in image field below and attach a copy of your child's birth certificate. Document must be .png or .jpeg only!!



Please click in image field below and attach a copy of your child's insurance below.
Document must be .png or .jpeg only!!

Please click in image field below and attach a copy of immunization records. Document must be .png or .jpeg only!!

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:

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

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

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

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

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call Debbie Connor at 404-217-5421

Signature: Date:

Submit Application