

### Brainy Kids Place Admission Information

Child Name	Date of Birth
Child's Home Address	Child's Home Telephone Number
My child will normally be in care the following days and times:	Date of Admission:

#### School Age Only

My child attends school at:			
<input type="checkbox"/> Barnett Elementary / 409-925-9700 <input type="checkbox"/> RJ Wollam Elementary / 409-925-2770	<input type="checkbox"/> Kubacak Elementary / 409-925-9604 <input type="checkbox"/> Santa Fe Junior High / 409-925-9300		
How will your child get to and from school?	School Bus	BKP Van	
<input type="checkbox"/> His/her immunization record is on file at the school and all required immunizations and/or tuberculous test are current. Vision and hearing screening are also on file.			
<input type="checkbox"/> My child has permission to ride the bus, walk to or from school or home, or to be released to the care of a sibling under 18 years old.			

#### Primary Contact

First and Last Name			
Email			
Phone Number	Mobile	Home	Work
Relationship to Child	Lives With	Emergency	Pick Up
Address Same as Child Other:			

#### Additional Contact

First and Last Name			
Email			
Phone Number	Mobile	Home	Work
Relationship to Child	Lives With	Emergency	Pick Up
Address Same as Child Other:			

#### Additional Contact

First and Last Name			
Email			
Phone Number	Mobile	Home	Work
Relationship to Child	Lives With	Emergency	Pick Up
Address Same as Child Other:			

Child lives with:	Both Parents	Mom	Dad	Guardian
Are there Custody Documents on File? <i>Custody Documents establish who has legal authority over and duty to care for a child (typical in cases of divorce, foster care, adoption, etc)</i> No    Yes, Submitted Date:				

**Medical Information**

Special Care Requirements (mark all that apply)	
<input type="checkbox"/> Environmental allergies	<input type="checkbox"/> Limitations or restrictions on child's activities
<input type="checkbox"/> Food Intolerances	<input type="checkbox"/> Reasonable accommodations or modifications
<input type="checkbox"/> Existing illness	<input type="checkbox"/> Adaptive equipment (include instructions below)
<input type="checkbox"/> Previous serious illness	<input type="checkbox"/> Symptoms or indications of complications
<input type="checkbox"/> Injuries and hospitalizations (past 12 months)	<input type="checkbox"/> Medications perscribed for continuous long term use
<input type="checkbox"/> Other:	
Explain any needs selected above:	
Does your child have an Individualized Educatin Plan (IEP) or an Individual Family Service Plan (IFSP) or any other related documents? No    Yes, Plan Submitted Date:	
Allergies (include any food or drug related)    None If so, Food Allergy Care Plan Submitted Date:	
My child has been examined in the last 12 months by the following pediatrician: Name: Address: Phone Number:	
My preferred emergency medical facility is: <input type="checkbox"/> Clear Lake Regional / 500 Medial Center, Webster, TX 77598 / 281-332-2511 <input type="checkbox"/> Mainland Medial Center / 6801 Emmett F Lowry Expy, Texas City, TX 77591 / 409-938-5000 <input type="checkbox"/> UTMB Galveston / 301 University Blvd, Galveston, TX 77555 / 409-772-1011	
I understand that I will be notified in case of an emergency. However, in the event that I cannot be reached, I authorize the calling of a doctor or EMS and the providing of the necessary medical services and treatment. I understand that Brainy Kids Place, LLC will not be responsible for medical expenses incurred, but that such expenses will be my responsibility as parent/ guardian.	
Sign	Date

**Permission Authorization (Initial Each One)**

<p><b>Transportation</b></p> <p><input type="checkbox"/> I hereby give consent for my child to be transported and supervised by Brainy Kids Place employees in the event of an emergency, a field trip (ages 4 and up), and/or to and from school.</p>
<p><b>Operational Policies and Procedures</b></p> <p><input type="checkbox"/> I acknowledge receiving the Brainy Kids Place Operational Policies and Procedures. I understand it is my responsibility to read and follow the guidelines and that reminders will be sent if needed. I will be notified of changes and may request a copy anytime. I understand non-compliance may result in dismissal of my child from services.</p>
<p><b>General Photo Release</b></p> <p><input type="checkbox"/> I hereby give Brainy Kids Place, LLC the right to take photographs of me and my family in connection with childcare experiences at the facility and on outings to field trips. I authorize Brainy Kids Place, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Brainy Kids Place may use such photographs with or without names and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.</p>

**Field Trips**

\_\_\_\_\_ I hereby give consent for my child (age 4 and up) to participate in field trips that are supervised by Brainy Kids Place employees. I understand that my child must be in a Brainy Kids Place shirt. I understand that my child will be expected to follow all rules and guidelines. I understand that I will be expected to pick up my child should they pose a safety risk.

**Sunscreen and Mosquito Spray**

\_\_\_\_\_ I consent to the application of sunscreen and/or mosquito spray I provide for my child, per the bottle instructions. I understand Brainy Kids Place does not supply these items.

**Registration**

\_\_\_\_\_ A Registration fee is Required. The first week's tuition is also due at the time of registration. Both the registration fee and the first week's tuition are non-refundable.

**Tuition and Late Payment Fees**

\_\_\_\_\_ Tuition must be paid in advance via Tuition Express by Friday for the upcoming week. Credit/debit card payments include applicable fees, while ACH bank drafts are fee-free. No cash payments are accepted at the center. Late payments incur a \$10 fee if not paid by Monday closing, with an additional \$10 charged daily until paid. Unpaid tuition by Thursday drop-off will result in denied care. Parents receiving Workforce Solutions aid must pay their Parent Fee by the 3rd of each month. Non-payment may result in termination of care and reporting to Workforce Solutions.

**Price Increases**

\_\_\_\_\_ Parents will receive 30 days' written notice of regular tuition increases, which occur at least annually for cost-of-living adjustments. Tuition may change without notice for summer care, classroom changes, schedule adjustments, or sibling discount changes.

**Late Pick Up**

\_\_\_\_\_ We cannot care for children outside of our operating hours. If someone is not here to pick your child up by closing time, each child will be charged a late pickup fee of \$15 and an additional \$15 per child after 30 minutes.

**Closures**

\_\_\_\_\_ Brainy Kids Place is closed for major holidays; details are available at the front desk. If a holiday falls on a weekend, we close the preceding Friday or following Monday. Tuition is non-refundable for holidays, weather, or unexpected closures.

**Absences**

\_\_\_\_\_ Tuition must be paid in full without deduction for absences of any duration or any cause. There will be no exceptions made. An unexplained absence of two weeks with no payment may mean that your child will be dis-enrolled and that place given to another child on our waiting list. No tuition adjustments will be made due to illness, scheduled holidays, or school closings. Part Time Days cannot be exchanged or made up for other days.

**Other Charges**

\_\_\_\_\_ There is an annual supply fee per child due by March 31 each year. Items such as nap mats, t-shirts for field trips, and extra diapers and/or wipes may be charged to your account and provided for your child if you have been notified your child will need this item and you fail to provide it when your child needs it. You may also be responsible for damaged property.

**Withdraw**

\_\_\_\_\_ Parents must provide two weeks' written notice of withdrawal and are responsible for tuition during this period, regardless of attendance. Failure to provide notice or make payments will result in a one-time written notice of charges owed, with 10 days to pay or resolve disputes. Unpaid balances may incur attorney or collection fees, plus 2% monthly interest from the due date.

**Other**

\_\_\_\_\_ Brainy Kids Place may terminate this contract immediately for non-payment, policy violations, or safety concerns. Non-enforcement of any term does not waive the right to enforce others. The contract may be revised in writing at any time. Unenforceable provisions will not affect the validity of the remaining terms.

# CACFP ENROLLMENT FORM

Please complete the following information:

Center Name: Brainy Kids Place, LLC

Phone Number: (409) 925-2437



Food & Nutrition Solutions

## Child 1:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Days in care: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Times in care: Start time \_\_\_\_\_ AM PM End time \_\_\_\_\_ AM PM

Meals Served to child while in care: Breakfast AM Snack Lunch PM Snack Supper EV Snack

Withdrawal Date (office use only): \_\_\_\_\_

## Child 2:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Days in care: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Times in care: Start time \_\_\_\_\_ AM PM End time \_\_\_\_\_ AM PM

Meals Served to child while in care: Breakfast AM Snack Lunch PM Snack Supper EV Snack

Withdrawal Date (office use only): \_\_\_\_\_

## Child 3:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Days in care: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Times in care: Start time \_\_\_\_\_ AM PM End time \_\_\_\_\_ AM PM

Meals Served to child while in care: Breakfast AM Snack Lunch PM Snack Supper EV Snack

Withdrawal Date (office use only): \_\_\_\_\_

## Child 4:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Days in care: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Times in care: Start time \_\_\_\_\_ AM PM End time \_\_\_\_\_ AM PM

Meals Served to child while in care: Breakfast AM Snack Lunch PM Snack Supper EV Snack

Withdrawal Date (office use only): \_\_\_\_\_

## Part 5. Signature (Adult must sign) An adult household member must sign and date this form.

I certify that all information on this form is true and correct. I understand that the center 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: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Meals will be provided to all children without charge. This center's CACFP is operated in accordance with the USDA's policies and does not permit discrimination on the basis of race, color, sex, disability, national origin, age, religion, or political belief. 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](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

## Part 6. Participant's ethnic and racial identities (optional) Mark one of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Hispanic or Latino   | <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> White |
| <input type="checkbox"/> Not Hispanic/ Latino | <input type="checkbox"/> Native Hawaiian / Other Pacific Islander  |

Dear Parent/Guardian:

**Brainy Kids Place, LLC**

This letter is intended for parents or guardians of children enrolled in a child care center. Brainy Kids Place, 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 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: Brainy Kids Place, LLC**

**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 **[enter name of staff person that handles complaints/disagreements]**, either in person or by telephone at **[enter phone number for the staff person above]**. You may ask for a hearing by calling or writing to: **[name, address, phone number]**.

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 (409) 925-2437

Sincerely,

**Brainy Kids Place, LLC**

July 2011

CACFP Meal Benefit Income Eligibility Form  
Letter to Households (Child Care Centers)



## 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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**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 case number

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

A. Name (List <b>only</b> 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
<i>(Example)</i> 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:	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> 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, 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 [redacted] (3027) found online at: <http://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;  
This institution is an equal opportunity provider.
- (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).