



### 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: Little Sheep Learning Center		Director's Name: Alysa K. Johnson	
Child's Full Name:		Child's Date of Birth:	Child Lives With? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> 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):	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No
<b>In case of an emergency, call:</b>			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation to release my child to leave the child care operation <b>ONLY</b> with the following persons. Please list 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	
<b>1. Transportation:</b>	
I give consent for my child to be transported and supervised by the operation's employees (Check all that apply). <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school	
<b>2. Field Trips:</b>	
<input type="radio"/> I give consent for my child to participate in field trips. <input type="radio"/> I do not give consent for my child to participate in field trips.	
Comments:	

**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).

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

**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:**

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

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

**Child's Special Care Needs (check 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 <i>(include instructions below)</i>
<input type="checkbox"/> Previous serious illness	<input type="checkbox"/> Symptoms or indications of complications
<input type="checkbox"/> Injuries and hospitalizations <i>(past 12 months)</i>	<input type="checkbox"/> Medications prescribed for continuous long-term use
<input type="checkbox"/> Other: _____	

Explain any needs selected above:

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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 III. 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 III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_

**School Age Children**

My child attends the following school:	School Area Code and Phone No.:
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My child has permission to *(check all that apply)*:

walk to or from school or home  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:

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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 No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and 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	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Admission Requirement

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

- Health Care Professional's Statement: I have examined the above named 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 child care 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	Date Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1-2 months (second dose)	
	6-18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	8 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	8 months (third dose)	
	15-18 months (fourth dose)	
	4-6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	8 months (third dose)	
	12-15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	8 months (third dose)	
	12-15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6-18 months (third dose)	
	4-6 years (fourth 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 (first dose)	
	4-6 years (second dose)	
Varicella	12-15 months (first dose)	
	4-6 years (second dose)	
Hepatitis A	12-23 months (first dose)	
	The second dose should be given 8 to 18 months after the first 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](http://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 child care 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>

Signatures

\_\_\_\_\_  
Child's Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Center Designee

\_\_\_\_\_  
Date Signed

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

# Parent Access Badge Agreement

**Between Good Shepherd Lutheran School and Parent/Guardian**

**Date:** \_\_\_\_\_

**Parent/Guardian Name(print):** \_\_\_\_\_

**Student(s) Name(print):** \_\_\_\_\_

To help keep our school safe we are shifting over to a new security method that will also allow us to have a more efficient time during pick up and drop off. Each family will be issued badges to open doors during our drop off and pick up window.

Each family will be issued two (2) badges at the beginning of the year. These badges will allow you access through the church building hallway and into the main building during the following times. The gate to the playground will be closed

**Drop Off- 6:30 AM to 8:15 AM**

**Pick Up - 3:15 PM to 6:30 PM**

If you arrive outside of these times you will need to use the video call buttons to request access to the school grounds.

Each family will be responsible for keeping track of and taking care of their badges. Replacement badges will be available in case of loss or damage at the cost of twenty-five dollars(\$25) per badge. Additional badges can also be purchased for twenty-five dollars(\$25) per badge.

**Lost or damaged badges need to be reported immediately to our IT department at [jonathanv@goodshepherdbastrop.org](mailto:jonathanv@goodshepherdbastrop.org)**

By signing below, you agree to follow the rules above for using a parent access badge.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**School Representative Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Emergency Contact Information

### General Information

Child's Name:	Date of Birth:
Address:	Primary Contact Phone:
Mom Cell:	Email Contact:
Dad Cell:	Email Contact:

### Medical Information

Allergies/Medical Conditions/Special Needs:
Other Information Emergency Personnel May Need to Know:

### Physicians Information

Name:	Phone:
Address:	

### Hospital Information

Name:	Phone:
Address:	

### Primary Emergency Contact

Name:	Relationship:	Primary Phone #:
Address:		Secondary Phone #:

### Secondary Emergency Contact

Name:	Relationship:	Primary Phone #:
Address:		Secondary Phone #:

My signature gives authorization for the above individuals to pick up my child from care and communicate on my behalf in the event of an emergency.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorized Pick-up Persons

### General Information

Child's Name:	Date of Birth:
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### Authorized Pick-up 1

Name:	Relationship:	Primary Phone #:
Address:		Secondary Phone #:

### Authorized Pick-up 2

Name:	Relationship:	Primary Phone #:
Address:		Secondary Phone #:

### Authorized Pick-up 3

Name:	Relationship:	Primary Phone #:
Address:		Secondary Phone #:

### Authorized Pick-up 4

Name:	Relationship:	Primary Phone #:
Address:		Secondary Phone #:

### Authorized Pick-up 5

Name:	Relationship:	Primary Phone #:
Address:		Secondary Phone #:

My signature gives authorization for the above individuals to pick up my child from care and communicate on my behalf in the event of an emergency. It is my responsibility to keep this list up to date and notify Little Sheep Learning Center of any necessary changes.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Discipline and Guidance Policy for \_\_\_\_\_

Name of Operation

- ◆ Discipline must be:
  - (1) Individualized and consistent for each child;
  - (2) Appropriate to the child's level of understanding; and
  - (3) Directed toward teaching the child acceptable behavior and self-control.
  
- ◆ A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  - (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  - (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  - (3) Redirecting behavior using positive statements; and
  - (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.
  
- ◆ There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  - (1) Corporal punishment or threats of corporal punishment;
  - (2) Punishment associated with food, naps, or toilet training;
  - (3) Pinching, shaking, or biting a child;
  - (4) Hitting a child with a hand or instrument;
  - (5) Putting anything in or on a child's mouth;
  - (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  - (7) Subjecting a child to harsh, abusive, or profane language;
  - (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed;and
  - (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Check one please:

parent       employee/caregiver       household member of child-care home



## MEDIA RELEASE

### Parent Release form for Photographing and of Videotaping

Student's LAST name: \_\_\_\_\_

Student's FIRST name: \_\_\_\_\_

I (check one) do  or do not  give permission for my child to be photographed or videotaped, by Little Sheep Learning Center staff member or a representative of Good Shepherd Lutheran Church to be used in connection with our web page, Facebook, classroom and/or program decoration or for instructional or marketing purposes. The intent of this release is to gain authorization from a parent/guardian to include your child's image. Permission may be limited to areas designated by the parent by opting out. To opt out of a selected area, draw a line through the area you desire to opt out of. I understand that I may revoke this permission at any time by notifying the LSLC office in writing at:

202 Highway 71 West OR  
PO Box 750  
Bastrop TX. 78602

Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

If there are any exceptions or special conditions please list below:

**LSLC**   
Little Sheep Learning Center  
**PERMISSION FOR PRAYER**

Little Sheep Learning Center is a ministry of Good Shepherd Lutheran Church and strives to fulfill the mission of the church:

**“Live God’s word and embrace all people.”**

One way we can do that is to pray, by name, for the children who are enrolled in our center, but we would not do so without your permission.

I do give permission for members and congregation of GSLC to pray for my child, \_\_\_\_\_.

I do not give permission for members and congregation of GSLC to pray for my child, \_\_\_\_\_.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



**TUITION AGREEMENT**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Paying Monthly  Paying Weekly

Payment for my child's program is due on Monday of each current week if I am paying weekly and by the 1<sup>st</sup> working day of each month if I am paying monthly, as specified in the current rate schedule. Tuition is payable according to the tuition schedule whether or not my child attends. If tuition and/or late fees are not paid by the 5th day, then I understand that my child cannot return to care until paid.

Parent initials \_\_\_\_\_

Weekly Tuition Amount \$ \_\_\_\_\_ Monthly Tuition Amount \$ \_\_\_\_\_

Non-refundable Registration Fee \$ 50

In the event of a NSF check return, a \$40 NSF check penalty will be added to my account and your payment will only be accepted in the form of a money order or cashiers check.

Parent initials \_\_\_\_\_

Our program is open Monday through Friday 6:30 am to 6:30 pm. Little Sheep Learning Center is only licensed by the Texas Department of Family and Protective Services to care for children during these specified times. If I am late picking up my child, a \$1 a minute late penalty will be charged to my account. Late penalties must be paid to Little Sheep Learning Center before the child can return to care. Regular attendance is imperative to your child's education. If your child will be absent, you agree to notify Little Sheep Learning Center by 8:30 am each day.

Parent initials \_\_\_\_\_

During summer months and holiday times, an activity fee may be charged. Activity fees are for additional activities outside our normal planned curriculum. Parents will be notified 30 days in advance of activity fee options.

Parent initials \_\_\_\_\_

Little Sheep Learning Center chooses not to get involved in custody disputes. In the event a court order is on file, Little Sheep Learning Center will not acknowledge which party is responsible for payment of tuition fees. These arrangements must be coordinated between the two parents. Late fees will still apply regardless of which parent is responsible for tuition fees.

Parent initials \_\_\_\_\_

In the event I choose to end my relationship with Little Sheep Learning Center and withdraw my child, a two week notice will be given in writing.

Parent initials \_\_\_\_\_

**SIBLING DISCOUNT:**

For 2 children attending Little Sheep Learning Center you will receive 10% off of the lowest tuition rate. For 3 or more children you will receive 15% off the lowest tuition rate.

\_\_\_\_\_  
Parent/Guardian Signature Date Director's Signature Date



A Ministry of Good Shepherd Lutheran Church

# Where we teach children God's love!

Our Mission:

Every child's educational and emotional journey begins with a core set of ingredients; a loving and supportive family, trusted caregivers and an environment that challenges each and every child regardless of his or her developmental stage.

Through their teaching, LSLC staff encourages the development of a Christian character and exemplifies the true meaning of a faith based center by providing the children with lesson plans and daily activities that reflect our God driven message. Our primary focus is to provide our children with faith based learning inside and outside the classroom.

1. What do you and your family need in a church?

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2. Are you okay with the church accessing your contact information (email, phone number, and mailing address) to receive invitations to worship and events, and to serve you in ministry efforts? Your information will be limited to these uses and will not be shared with outside parties under any circumstances.

Yes

No



### Acknowledgement of Parent Handbook

My signature verifies I have read and received a copy of the Parent Handbook which outlines the operation policies for Little Sheep Learning Center.

All of my questions have been answered.

If I have any other questions I will ask as soon as possible.

Guardian/parent must review and sign.

Printed Name:	Signature:	
Relationship:		Date:

Printed Name:	Signature:	
Relationship:		Date:

Printed Name:	Signature:	
Relationship:		Date:

Printed Name:	Signature:	
Relationship:		Date:

Child's Name:	Enrollment Date:
Child's Name:	Enrollment Date:
Child's Name:	Enrollment Date:
Child's Name:	Enrollment Date:

### **Purpose:**

These questions are designed to give you the information needed to provide the best, most appropriate care for children. This information is confidential and parents must be reassured it will not be shared without their written permission.

Experts in the field recommend completing an assessment form for each child. It can help start mutual trust and respect that will develop into a strong, cooperative partnership between parents and caregivers.

The assessment should be completed prior to enrollment. Give parents an opportunity to review your enrollment forms and parent handbook before you complete the assessment form. The parent handbook or operational policies set forth your program's philosophy and values.

The enrollment interview is the time to obtain critical information about the child and provide information on your program's operational policies, such as health checks (if conducted), procedures for the release of children, and illness and exclusion criteria. It also provides parents an opportunity to assess your program and determine if it is best suited for their child's needs.

# Child Assessment Form

Child Name (last, first, middle)	Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)	City	County	Zip
Mailing Address (if different) -- Street or P.O. Box	City	County	Zip
Telephone No. (include A/C)			

\* If applicable.

## 1. Health

Does your child have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## 2. Toileting:

Does your child need assistance with toileting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

## 3. Behavior:

Does your child have any special fears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child communicate his/her needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		

# Child Assessment Form

What position is most comfortable for your child when he/she is napping?	
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#### 4. Eating Preferences:

What are your child's favorite foods?	
Does your child use utensils, eat with fingers, feed self?	
Does your child choke easily while eating?	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### 5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

#### 6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	
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I verify that the above assessment was discussed with the parent(s) of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Director

\_\_\_\_\_  
Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date Signed

#### Additional Comments:

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# Infant Declaration Form:

Center Name \_\_\_\_\_

## INSTRUCTIONS TO PARENTS:

Complete BOTH sections on this form. Sign and date where indicated. Submit to child care provider.

**Section 1**

Infant's Name \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent's Name \_\_\_\_\_

My child is allergic to the following foods:  
(A Doctor's note is required for any foods that cannot be substituted within the same food group.)

\_\_\_\_\_

**Section 2**

Your child care provider offers the following iron-fortified infant formula(s): \_\_\_\_\_

Parent Declaration - **Select only ONE of the following options.**

**CENTER** will provide ALL meal components for infant named above.

or

**PARENT** will provide ALL meal components for infant named above.

or

**BOTH PARENT and CENTER** will provide meal components for infant named above, as indicated below.

			0-5 Months	6-11 Months
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Iron Fortified Infant Formula / Breast Milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	↳ _____ Infant Formula Brand Name	<input type="radio"/>		
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Iron Fortified Infant Cereal			<input type="checkbox"/>
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Infant Fruits/Vegetables			<input type="checkbox"/>
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Infant Meats			<input type="checkbox"/>
<input type="radio"/> Center or <input type="radio"/> Parent	will provide Crusty Bread/Crackers			<input type="checkbox"/>

\*\*\* This form must be updated and submitted any time there is a change in Section 2.

I understand that once my infant child turns 6 months of age, it is my responsibility to notify the child care center director as to any limitations of solid foods that my infant child is not developmentally ready to receive.

\_\_\_\_\_  
Parent Signature

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Parent Phone Number Date

\*Please include your phone number so our CACFP Sponsor can contact you if they have any questions.

For Sponsor Use Only

\_\_\_\_\_



Center Name \_\_\_\_\_

### CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members			
Names of all household members (First, Middle Initial, Last)	CHECK IF ENROLLED CHILD	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"/>	<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 4.  
 NAME: \_\_\_\_\_ ELIGIBILITY NUMBER: \_\_\_\_\_  
\*SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.

**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 <b>only</b> household members with income)	B. Gross income and how often it was received <b>Note:</b> 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							
	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	Weekly	Every 2 Weeks	2x Month	Monthly	Annually	Weekly	Every 2 Weeks	2x Month	Monthly	Annually
<i>Example: Jane Smith</i>	\$ 200	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ 150	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$ 100	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$ 100	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>	\$ _____	<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"/>	<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"/>	\$ _____	<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"/>	<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 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)

<b>Part 6. Participant's ethnic and racial identities (optional)</b>	
<b>Mark one ethnic identity:</b>	<b>Mark one or more racial identities:</b>
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White
	<input type="checkbox"/> Black or African American
	<input type="checkbox"/> American Indian or Alaska Native
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<b>Part 7. Sharing Information With Other Programs: OPTIONAL</b>	
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.	
<input type="checkbox"/> I <u>do</u> elect to allow my household information to be disclosed.	
<input type="checkbox"/> I <u>do not</u> elect to allow my household information to be disclosed.	
<b>Don't fill out this part. This is for official use only.</b>	
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12	
Total Income: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> 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: _____	
<b>Privacy Act Statement:</b>	
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.	
<b>Non-discrimination Statement:</b>	
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: <a href="https://www.usda.gov/sites/default/files/documents/ad-3027.pdf">https://www.usda.gov/sites/default/files/documents/ad-3027.pdf</a> , 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;	
(2) fax: (833) 256-1665 or (202) 690-7442;	
(3) email: <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a> .	
This institution is an equal opportunity provider.	

This letter is intended for the parents or guardians of children enrolled at:

Dear Parent/Guardian:

This child care 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 the child care center's director.**
- 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 speak to Amy Pringle by telephone at (832) 282-1351. You may ask for a hearing by calling or writing to Max Taylor, Advance Child Care, Inc.; 523 West First Ave; Corsicana, Texas 75110, (903)872-5231.**

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 Amy Pringle at (832) 282-1351.

Sincerely,

**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 determinar 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

**INSTRUCTIONS FOR  
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM  
(CHILD CARE)**

**Follow these instructions, if your household gets SNAP, TANF or FDPIR:**

**Part 1:** List all enrolled children and household members.

**Part 2:** List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC (see illustration).

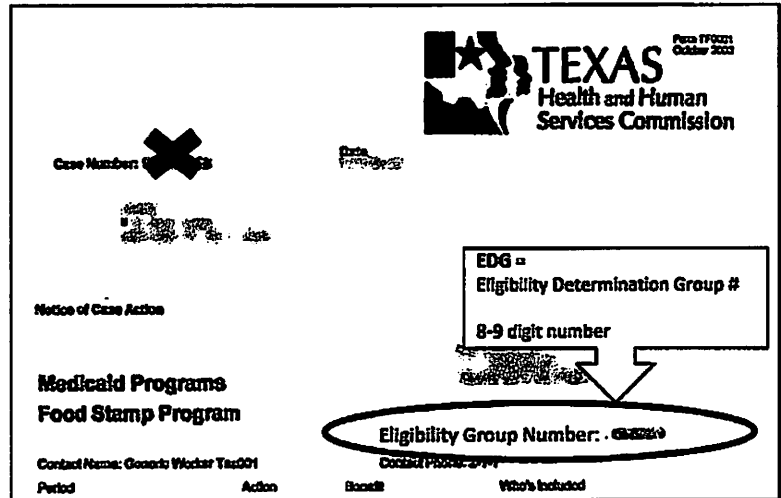
**Part 3:** Skip this part.

**Part 4:** Skip this part.

**Part 5:** Sign the form. The last four digits of a Social Security Number are **not** necessary.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.



**If you are applying on behalf of a FOSTER CHILD, follow these instructions:**

**If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:**

**Part 1:** List all foster children. Check the box indicating that the child is a foster child.

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Skip this part.

**Part 5:** Sign the form. A Social Security Number is **not** necessary.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

**If some of the children in the household are foster children.**

**Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

**Part 2:** If the household does not have an eligibility number, skip this part.

**Part 3:** Applies only to parents/guardians of children in Tier II Day Care Homes. Sponsors must provide the *List of Eligible Federal/State Funded Programs (H1660)*, with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.

**Part 4:** Follow these instructions to report total household income from this month or last month.

**Column A – Name:** List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B – Gross Income and How Often it was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. See next.

**Box 1:** List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

**Box 2:** List the amount each person got for the month from welfare, child support, alimony. **Box 3:** List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

**Box 4:** List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

**Part 5:** Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

**ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:**

**Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Follow these instructions to report total household income from this month or last month.

**Column A – Name:** List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B – Gross Income and How Often it was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

**Box 1:** List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

**Box 2:** List the amount each person got from the month from welfare, child support, alimony.

**Box 3:** List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

**Box 4:** List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

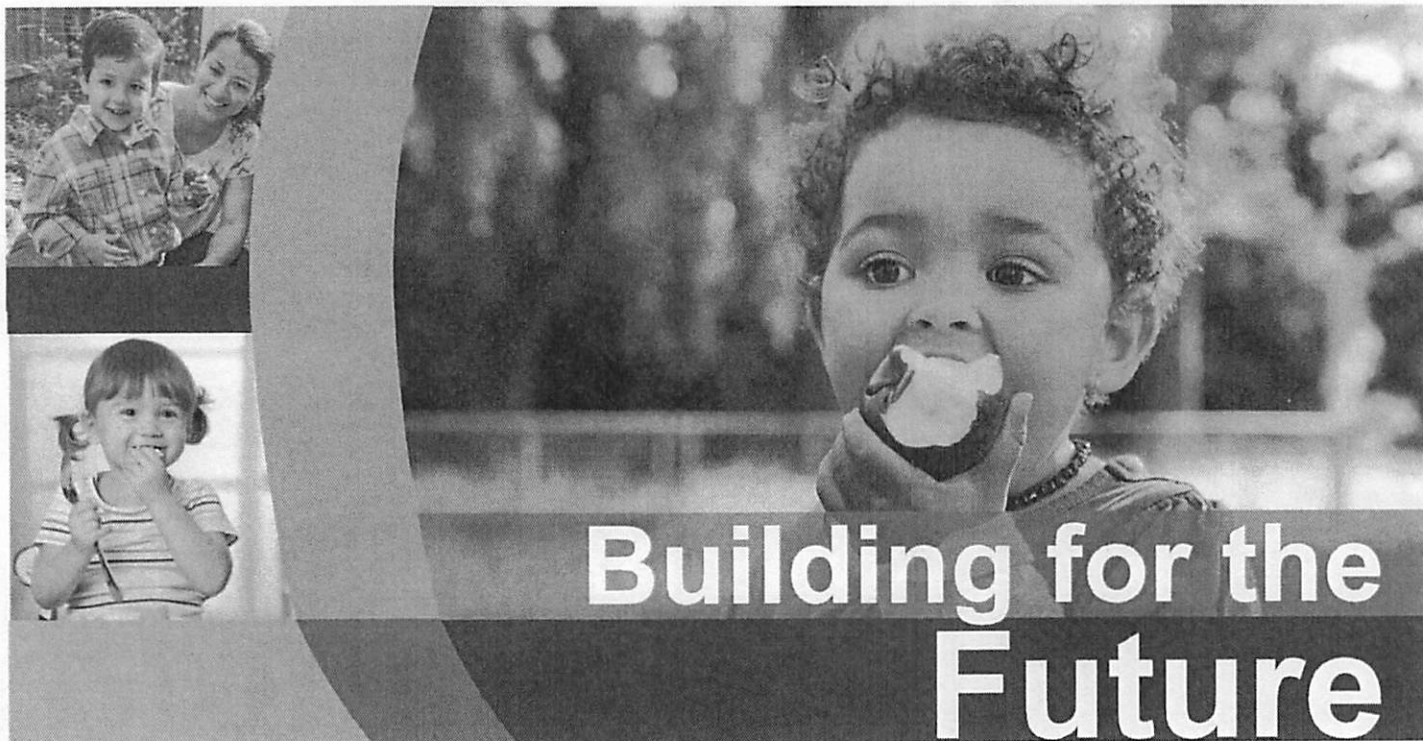
**Part 5:** Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

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

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly.



# Building for the Future

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

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

OR

## Your child care at Little Sheep Learning Center

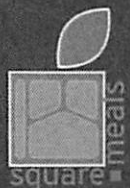
**Contact Information:** Dana Heidemeyer

**Address:** 202 Tx Hwy 71 W

**Phone Number:** 512-988-1778

**Email Address:** [admin@goodshepherdbastrop.org](mailto:admin@goodshepherdbastrop.org)

**Other Necessary Information:**



Food and Nutrition Division  
Child and Adult Care Food Program

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  
Toll Free: (877) TEX-MEAL | For the hearing impaired: (800) 735-2989 (TTY)

This product was funded by USDA.  
This institution is an equal opportunity provider.



Updated 11/17/2021  
[www.SquareMeals.org](http://www.SquareMeals.org)



# Construyendo Para El Futuro

Este cuidado infantil recibe asistencia federal en efectivo para server comidas saludables a sus hijos. Una Buena nutricion hoy en dia significa una manana mas fuerte.

Las comidas servidas aqui cumplen con los requisitos de nutricion establecidos por el Programa de Alimentos para el Cuidado de Ninos y Adultos (Child and Adult Care Food Program) de USDA.

## ¿Preguntas? ¿Preocupaciones?

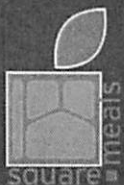
Llame gratuitamente a USDA al  
1-866-873-2263

División de Alimentos y Nutrición al  
1-800-TELL-TDA  
(835-5832)

OR

## Centro de cuidado de niños de su hijo al Little Sheep Learning Center

Contact Information: Dana Heidemeyer  
Address: 202 Tx Hwy 71 W  
Phone Number: 512-988-1778  
Email Address: [admin@goodshepherdbastrop.org](mailto:admin@goodshepherdbastrop.org)  
Other Necessary Information:



Food and Nutrition Division  
Nutrition Assistance Programs

## DEPARTEMENTO DE AGRICULTURA DE TEXAS COMISIONADO SID MILLER

Línea directa de fraude: 1-866-5-FRAUD-4 o 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711  
Llamada gratuita: (877) TEX-MEAL | Para personas con problemas de audición: (800) 735-2989 (TTY)

Este producto fue financiado por el USDA.  
Esta institución proporciona igualdad de oportunidades.



Updated 11/17/2021  
[www.SquareMeals.org](http://www.SquareMeals.org)

# 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](https://TexasWIC.org)**



This institution is an equal opportunity provider.

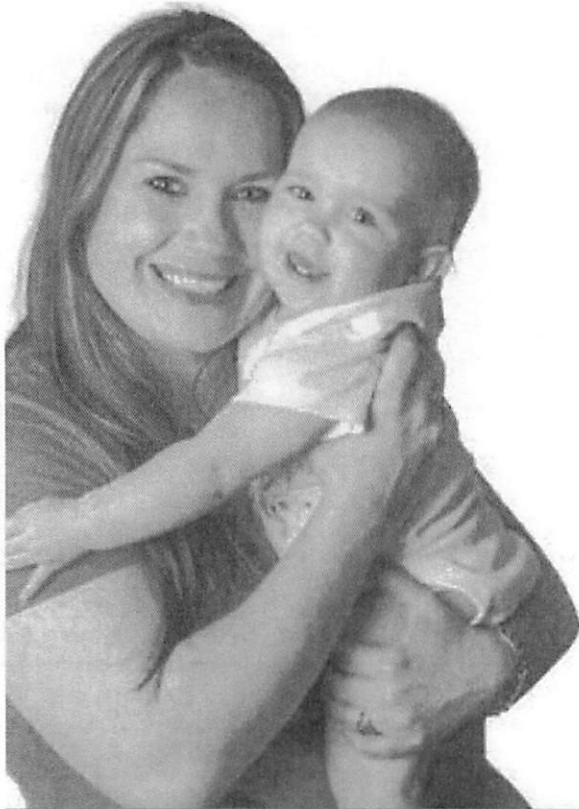
© 2020 All rights reserved. Stock no. 13-06-15123 Rev. 5/21

# Ven a WIC de Texas

## Estamos aquí para servirte

“Gracias a WIC, ahora tengo las herramientas que necesito para asegurar que mi familia siga el camino hacia un estilo de vida saludable.”

—Roxie, cliente de WIC



### Como cliente de WIC, recibirás:

- Alimentos deliciosos
- Asesoramiento individualizado con nutricionistas
- Recetas sencillas de preparar
- Clases sobre nutrición
- Apoyo para la lactancia
- Evaluaciones médicas y sobre las vacunas
- Demostraciones de cocina
- Apoyo personalizado
- Actividades para niños

### ¿Calificas?

Ocho millones de mujeres, bebés y niños reciben beneficios de WIC. El Programa WIC va dirigido a mujeres embarazadas, nuevos padres, bebés y niños menores de cinco años. Si ya recibes Medicaid, TANF o SNAP, es posible que califiques.

### Requisitos de ingresos de WIC de Texas

Número de personas en el hogar*	Ingresos mensuales	Ingresos anuales
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

Vigente a partir del 1 de abril de 2024

\* El número de personas en el hogar de una mujer embarazada aumenta según los bebés que espera. Si son más de seis personas, llama a la oficina local de WIC.

\*\* Los ingresos también se calculan por semana o por quincena.

**Empieza hoy mismo. Llama al 1-800-942-3678 o visita [TexasWIC.org](http://TexasWIC.org)**



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