Bay Area Child Development Center, Inc.

5215 Embassy Dr.
Corpus Christi, TX 78411
Tel: (361) 857-6543
Fax: (361) 857-2622

4926 Greenwood Dr.
Corpus Christi, Texas 78416
Tel: (361) 225-2005
Fax: (361) 225-2002

LIST OF REQUIRED REGISTRATION INFORMATION

Enroll Date: _____ Withdraw Date: _____ Accepted By: _____

1. Admission Information: _____
2. Enrollment Agreement: _____
3. Signature of Parent Handbook: _____
4. Physician's Statement & Vision/Hearing _____
5. Lights Camera Action Consent and Release: _____
6. Copy of Current Immunization:
    a) Updated:_____
    b) Updated:_____
    c) Updated:_____
    d) Updated:_____
7. CACFP Forms: _____
    a) Enrollment Form Participation: _____
    b) Eligibility Form: _____
8. Discipline and Guidance Policy: _____
9. Addendum to Parent Handbook: _____
10. Enrollment Financial Information: _____

Parent Information updated on:

_____ _____
Parent Initial Date:

_____ _____
Parent Initial Date:

_____ _____
Parent Initial Date:

_____ _____
Parent Initial Date:

_____ _____

Enrollment Information

Enroll Date: _____ *Withdraw Date:* _____ Accepted By: _____

Child's Name: _____ D/O/B: _____ Home #: _____

Child's Address: _____

Street City State Zip

Mother's Name: _____ SS#: _____

Father's Name: _____ SS#: _____

Address if different: _____

Street City State Zip

Phone numbers while child is in care: Mother: WK: _____ Cell #: _____

Father: WK: _____ Cell#: _____

Days and Hours expected to be in care: **F/T** **P/T** (Circle one)

Emergency contact (MUST BE OTHER THAN PARENT IF HE/SHE CANNOT BE REACHED)

Name: _____ PH#: _____ Relationship: _____

Address: _____

Street City State Zip

I hereby authorize the day care facility to allow my child to leave the day care facility ONLY with the following persons (include parent's name). I understand that all persons listed to pick up the child will provide a copy of a current Driver's License and that any changes to this list must be in writing by the parent to the center. There are no exceptions to this rule:

_____ PH# _____/_____ PH#: _____

_____ PH#: _____/_____ PH#: _____

_____ PH#: _____/_____ PH#: _____

_____ PH# _____/_____ PH#: _____

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medication prescribed for long-term continuous use, and other information which should be aware of:

_____

_____

_____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:
Physician: _____ Address: _____ PH#: _____

Hospital: _____ Address: _____ PH#: _____

ONE OF THE FOLLOWING STATEMENTS MUST BE FILLED IN AND DOCTOR'S STATEMENT RECEIVED WITHIN 6 WEEKS OF ENROLLMENT:

1) **SCHOOL AGE CHILDREN**: My child attends the following school and his/her immunization record is on file at the school. Immunizations and tuberculosis test results are current:

   School: _____ Address: _____ PH#: _____

2) **DOCTOR'S STATEMENT**: My child has been examined within the past year by a licensed physician and is able to participate in the day program: *Name and address of physician:*_____

   (Within the next 6 weeks, I will obtain a physician's statement, a copy of the medical screening form from the EPSDT program, or a formal statement from a health service of clinic and will submit it to the day care facility).

3) **MY CHILD HAS AN APPOINTMENT FOR A PHYSICAL EXAMINATION ON**:

   _____ Date: _____

   Name and address of Physician or address of EPSDT screening site: (I will submit the physician's statement, EPSDT form, or health service or clinic form to the day care facility following the examination).

_____ Date: _____

Signature of parent

Bay Area Child Development Center, Inc.

ENROLLMENT AGREEMENT

I, _____ (Parent) agree that Bay Area Child Development Center, Inc. will care for _____, child(ren) beginning on _____, 20_____.

Care will include the following meals and snacks: (circle those that will be provided):

Breakfast Lunch PM Snack Supper

I understand and agree to pay a weekly/monthly fee of $ _____. I understand that payment for childcare is due on the Monday of each week wherein payment would be made in advance for care. If this fee is not paid on the first day of the week, a late penalty of $5.00 per day will be charged daily until paid in full. Continuous late fees will be grounds for termination or participation in our daycare program.

Parents of children who are on the Workforce Program are required to pay the first half of the required parent fee on the 1st of the month and the second half on the 15th. Unless specific arrangements are made with the staff a late charge of $25.00 will be added for late fees.

My child(ren) is (are) to be in care between the hours of:

_____and_____on _____.

Arrival Departure Days of the Week

Late pick up for children left at the center outside of normal hours of operation will require an additional fee of $5.00 per minute, per child that is kept in care after the 7:00 closing time and will be due upon pick up of the child(ren).

WHEN I WITHDRAW MY CHILD(REN) FROM CARE, I AGREE TO GIVE AT LEAST A 2 WEEKS ADVANCE NOTICE AND UNDERSTAND I WILL BE BILLED FOR THE TWO WEEKS IF NOTICE IS NOT GIVEN IN WRITING.

If nonpayment is the cause for termination, the 2 weeks notice will still be charged when care is terminated. In case suit or action is instituted to collect any portion thereof, the below named buyer(s) promises to pay all collection costs and such additional sums as the court may adjudge reasonable such as court costs, attorneys fees, services of process, etc. in said suit or action.

_____/ _____/ _____/ _____

Signature of Parent/Legal Guardian Social Security # Drivers' License # Date

Bay Area Child Development Center Parent Handbook
Policy Acknowledgement

I, _____ACKNOWLEDGE, I have received a copy of the Parent Handbook for BACDC, and hereby agree to abide by the aforementioned policies as my child/ren is/are enrolled in this center. I further understand that upon withdrawal from the center, I must give a 2 weeks advance, and that I am obligated for payment of tuition until final withdrawal.

_____Date:_____
Parent or Guardian

Bay Area Child Development Center, Inc.
5215 Embassy Dr. Corpus Christi, TX 78411 Tel: (361) 857-6543 Fax: (361) 857-2622
4926 Greenwood Dr. Corpus Christi, TX 78416 Tel: (361) 225-2005 Fax: (361) 225-2005

Director:

PHYSICIAN'S STATEMENT

Date: _____

TO WHOM IT MAY CONCERN:

_____ was seen in our office on _____. This child was found to be in good physical health and may participate in all daycare activities. For further information, please contact our office at ( ) _____.

Thank You,

_____
Physician's Signature

VISION/HEARING SCREENING FOR 4 YR. OLDS

Hearing: _____ Date: _____ Signature: _____

HZ _____ **1000** _____ **2000** _____ **4000** _____ **Pass** _____

R _____ **L** _____ **Fail** _____

Vision: _____ Date: _____ Signature: _____

R20/_____ **L20/**_____ **Pass** _____ **Fail** _____

Bay Area Child Development Center, Inc.
Lights, Camera, Action

Consent and Release

Occasionally, Bay Area Child Development Center Inc., its affiliate company, and or other oral news media will take photographs of children participating in the various programs at Bay Area Child Development Center Inc. These photos and/or videotapes may be used from time to time in various forms of advertising media (brochures, magazines, orientations, trainings, public television, or newspaper).

I give my permission for Bay Area Child Development Center Inc. and/or agents to use any photographs and/or videotapes including my child for any and or media purpose without compensation.

PERMISSION GRANTED:_____ PERMISSION DENIED:_____

_____ _____
PARENT/GUARDIAN Date

_____ _____
DIRECTOR/ASST. DIRECTOR/REPRESENTATIVE Date

Bay Area Child Development Centers, Inc.

5215 Embassy Dr.
Corpus Christi, TX 78411
Tel: (361)-857-6543
Fax: (361)-857-2622

4926 Greenwood Dr.
Corpus Christi, Texas 78416
Tel: (361) 225-2002
Fax: (361) 225-2005

CACFP Documentation Acknowledgement

I hereby acknowledge that I have received the following information concerning the USDA Food Program:

1. Building for the Future;
2. WIC: The Special Supplemental Nutrition Program for Women, Infants & Children;
3. Non-Pricing form;
4. Right of Refusal; and
5. Civil Rights Information.

_____ _____Date: _____

Child's Name Parent Signature

Dear Parents:

Bay Area Child Development Centers, Inc. is operated 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 USD
A 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:

(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: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact info/hotlines.htm.

USDA is an equal opportunity provider and employer.

Child's Name: _____ Enroll date: _____
Hours and days of service and meals approved:

_____-_____=_____ days per week

I authorize my child to receive the following (circle all that apply):
Breakfast Lunch Afternoon Snack Dinner

_____

Parent Signature Date:

Bay Area Child Development Center, Inc.

CHILD ENROLLMENT FORM FOR PARTICIPATION

IMPORTANT NOTICE: THIS FORM MUST BE COMPLETED BY PARENT OR GUARDIAN ONLY AT TIME OF ENROLLMENT, AND MUST BE UPDATED YEARLY. Failure to complete form will result in non-payment for this child's meals for this child care center.

FIRST NAME OF CHILD:_____ LAST NAME:_____

DATE ENROLLED:_____ DATE OF BIRTH:_____

NORMAL HOURS IN CARE:

Earliest Arrival Time_____ am ____ pm _____ Latest Departure Time_____ am ____ pm_____

MEASL and/or SNACKS NORMALLY SERVED TO CHILD IN CARE (Mark all that apply)

Breakfast_____ Lunch_____ PM Snack_____ Dinner _____

NORMAL DAYS IN CARE (mark all that apply):

Monday_____ Tuesday_____ Wednesday_____ Thursday_____ Friday_____

RACE/ETHNICTY

White_____ Black/African American_____ American Indian/Alaska Native_____ Asian_____

Hispanic/Latino_____ Native Hawaiian/ Other Pacific Islander_____ Unknown_____

SEX OF CHILD MALE_____ FEMALE_____

DATE WITHDRAWN _____

In accordance with Federal Law, U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination write to: USDA, Director, Office of Civil Rights, 1400 Independence Avenue S.W, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382(TTY). USDA is an equal opportunity provider and employer.

PARENT/GUARDIAN FIRST NAME:_____ LAST NAME:_____

ADDRESS: _____ CITY:_____ ZIP CODE: _____

HOME TEL. NUMBER: (_____)_____ WORK TEL. NUMBER(_____)_____

I certify that I have received a Building for the Future flyer notifying me that this provider receives federal cash assistance to serve healthy meals to my child(ren) which must meet nutrition requirements established by USDA's Child and Adult Care Food Program. In addition, I have received W.I.C. program flyer.

_____ _____

Signature of Parent or Guardian Date Signed

Discipline and Guidance Policy for:
Bay Area Child Development Center

- 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

TDPRS-CCL 06/02/03

Infant Care Instructions

Dear Parent,

In order to serve your infant's needs in a more individual manner, we ask that you fill out this form and return it to the nursery.

Baby's Name: _____ Baby's Birthday: _____

Type of Formula (Be specific) _____ Warmed? _____

Type of juice(s) _____

Type of Diet: Cereal _____ Meats _____

Vegetable _____ Fruits _____

Table Food (11 months and up): _____

Allergies: Food _____

Skin _____

Other _____

Skin Care: Ointment _____ Special soap _____

Sleeping position: On Stomach _____ On Back _____ On Side _____

Does your baby use a pacifier? _____

OTHER HELPFUL INFORMATION (Please include schedule for feeding, sleeping, etc.)

_____

_____

_____

Thank You for sharing your child with us!!!!

_____ _____

Parent Signature Date

Update:

_____	_____	_____
Changes	Parent Initial	Date
_____	_____	_____
Changes	Parent Initial	Date
_____	_____	_____
Changes	Parent Initial	Date
_____	_____	_____
Changes	Parent Initial	Date
_____	_____	_____
Changes	Parent Initial	Date

CACFP Infant Feeding Preference-Centers

Infants Name_____ Infant's Date of Birth _____

Bay Area Child Development Center II Inc. will feed your infant breast milk provided by you and/or we will provide iron fortified infant formula.

The infant formula provided by this center is: ***Similac Advanced***

This center participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires centers to follow specific meal patterns according to the age of the infant.

Centers participating in the CACFP are required to offer infant formula to infants who are enrolled for child care. Parents (or guardians) may decline the infant formula offered by the center, and supply the infant's formula.

Parents (or Guardians) complete the following table(s) as appropriate:

Please mark your preference (Choose all that apply)	**Today's Date** _____ **Birth-3 months**	**Today's Date** _____ **4-7 months**	**Today's Date** _____ **8-11 months**
I will bring expressed breast milk for my infant.			
I want the center to provide the infant formula for my infant.			
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring: _____			

According to CACFP requirements, in order to claim meals for reimbursement, the center must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	**Today's Date** _____ **4-7 months**	**Today's Date** _____ **8-11 months**
I want the center to provide the infant cereal and other foods for my infant.		
I will bring the infant cereal and/or other foods for my infant.		

Parent's (Guardian's) signature _____ Date _____

1. This form should be kept on file for each infant enrolled for child care.
2. This form should be kept current and accurate for each infant enrolled for child care until the infant reaches one year of age.
3. If the parent (or guardian) declines the formula and the center provides meal and/or snack components, the meal may be claimed for reimbursement.
4. If the parent (or guardian) declines infant meals/snack, meals and snacks may NOT be claimed for reimbursement.

Bay Area Child Development Center, Inc.
5215 Embassy Dr.
Corpus Christi, TX 78411

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Bay Area Child Development 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: [(Name of Center, address, phone number].**

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 361-857-6543

Sincerely,

Anita A. May
President/Owner**]**

WIC --The Special Supplemental Nutrition Program for Women, Infants and Children

1. What is WIC?

WIC provides nutritious foods, nutrition education (including breastfeeding promotion and support), and referrals to health and other social services to participants at no charge. WIC serves low-income pregnant, postpartum and breastfeeding women, and infants and children up to age 5 who are at nutrition risk.

The Texas Department of State Health Services (DSHS) administers this Federal program in Texas, to pay for WIC foods, nutrition education, breastfeeding promotion and support, and administrative costs.

2. Who is eligible?

Pregnant women, women who are breastfeeding a baby under 1 year of age, women who have had a baby in the past six months, and parents, step-parents, guardians, and foster parents of infants and children under the age 5 can apply for their children. To be eligible on the basis of income, applicants' income must fall at or below 185% of the U.S. Poverty Income Guidelines (see below).

A person who participates or has family members who participate in certain other benefit programs, such as the Supplemental Nutrition Assistance Program, Medicaid, or Temporary Assistance for Needy Families, automatically meets the income eligibility requirement.

WIC INCOME GUIDELINES
The WIC income guidelines below are effective beginning
July 1, 2016

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	$21,978	$1,832	$916	$846	$423
2	$29,637	$2,470	$1,235	$1,140	$570
3	$37,296	$3,108	$1,554	$1,435	$718
4	$44,955	$3,747	$1,874	$1,730	$865
5	$52,614	$4,385	$2,193	$2,024	$1,012
6	$60,273	$5,023	$2,512	$2,319	$1,160
7	$67,951	$5,663	$2,832	$2,614	$1,307
8	$75,647	$6,304	$3,152	$2,910	$1,455
For each additional family member add:	$7,696	$642	$321	$296	$148

3. What is "nutrition risk?"

Two major types of nutrition risk are recognized for WIC eligibility:

- Medically-based risks such as a history of poor pregnancy outcome, underweight status, or iron-deficiency anemia, and
- Diet based risks, such as poor eating habits that can lead to poor nutritional and health status.

Nutrition risk is determined through an initial health and diet screening at the WIC clinic.

4. What are the Health Benefits of WIC?

Studies show that WIC plays an important role in improving birth outcomes and containing health-care costs. WIC has a positive impact on children's diets. WIC improves infant-feeding practices by actively promoting breastfeeding as the best method of feeding infants. WIC clients have improved rates of childhood immunizations and a regular source of health care.

- Improved infant-feeding practices
- Premature births reduced
- Fetal death rate reduced
- Low birthweight reduced
- Long-term medical expenses reduced
- Improved dietary intake
- Improved cognitive development
- Fewer premature births

5. How do I contact DSHS about WIC?

Call toll free at (800) 942-3678 or (800) WIC-FOR-U; or go online to http://www.dshs.state.tx.us.

WIC – El programa especial de nutrición suplementaria para mujeres, bebés y niños

1. ¿Qué es WIC?

WIC ofrece alimentos nutritivos, educación sobre la nutrición (que incluye apoyar y promover a que las madres den el pecho al bebé), así como referidos a servicios de la salud y otros servicios sociales gratuitos para los participantes. WIC ofrece estos servicios a mujeres de bajos ingresos durante el embarazo, en el postparto y cuando están dando el pacho a sus bebés, y también a los niños con riesgos de problemas de nutrición hasta los 5 años de edad.

El Departamento Estatal de Servicios de Salud de Texas (DSHS) administra este programa federal en Texas, cuyo objetivo es pagar por los alimentos de WIC, la educación sobre la nutrición, promover y apoyar a que las madres den el pecho al bebé y los gastos administrativos.

2. ¿Quién califica?

Las mujeres embarazadas, las mujeres que estén dando pecho a un bebé menor de 1 año de edad, las mujeres que han tenido un bebé en los últimos seis meses, así como los padres, padrastros, tutores y padres de crianza de los bebés y niños menores de 5 años, pueden presentar una solicitar en nombre de sus niños. Para poder calificar a base de ingresos, los ingresos del solicitante deberán ser iguales o menores al 185% de los lineamientos de ingresos de pobreza de Estados Unidos (véase abajo).

Una persona que participe o tenga miembros de su familia que participen en ciertos otros programas de prestaciones, tales como el Programa de Asistencia de Nutrición Suplementaria, Medicaid, o Asistencia Temporal para Familias Necesitadas, automáticamente cumplirá el requisito de calificación por ingresos.

LINEAMIENTOS DE INGRESOS de WIC
Los siguientes lineamientos de ingresos de WIC se aplican a partir de
1 de julio de 2016

TAMAÑO DE LA FAMILIA	ANUAL	MENSUAL	DOS VECES AL MES	CADA DOS SEMANAS	WEEKLY
1	$21,978	$1,832	$916	$846	$423
2	$29,637	$2,470	$1,235	$1,140	$570
3	$37,296	$3,108	$1,554	$1,435	$718
4	$44,955	$3,747	$1,874	$1,730	$865
5	$52,614	$4,385	$2,193	$2,024	$1,012
6	$60,273	$5,023	$2,512	$2,319	$1,160
7	$67,951	$5,663	$2,832	$2,614	$1,307
8	$75,647	$6,304	$3,152	$2,910	$1,455
Para cada miembro adicional de la familia, aumente:	$7,696	$642	$321	$296	$148

3. ¿Qué es el "riesgo nutricional?"

Para propósitos de calificación en WIC, se reconocen dos tipos principales de riesgos nutricionales:

- Los riesgos médicos, tales como una historia de mala evolución del embarazo, estado de bajo peso, o anemia por deficiencia de hierro, y

- Los riesgos alimentarios, tales como prácticas inadecuadas de nutrición que puedan conducir a un mal estado nutricional y de la salud.

El riesgo nutricional se determina con una evaluación inicial de salud y de la nutrición en la clínica de WIC.

4. ¿En qué manera se beneficia la salud de una persona con WIC?

Los estudios demuestran que WIC juega un papel importante en la mejora de los resultados del parto y que controla los costos de la atención médica. WIC tiene un impacto positivo en la nutrición de los niños. WIC mejora las prácticas de alimentación infantil, y fomenta a que las madres den el pecho a sus bebes, como el mejor método de alimentación de los bebés lactantes. Los niños que participan en WIC se vacunan y reciben atención médica con más frecuencia.

- Mejora en las prácticas de alimentación infantil
- Reducción de los partos prematuros
- Reducción de la tasa de mortalidad fetal
- Reducción del bajo peso al nacer
- Reducción de los gastos médicos a largo plazo
- Mejora en la calidad de alimentos
- Mejora en el desarrollo cognitivo
- Reducción de los partos prematuros

5. ¿Cómo me comunico con DSHS para averiguar sobre WIC?

Llame gratis al (800) 942-3678 o al (800) WIC-FOR-U; o visite el sitio http://www.dshs.state.tx.us.

Instructions - Income Eligibility Guidelines for Determining Free and Reduced-Price Benefits (H1625-A)

Contracting entities must give this form to Program participants annually and potential participants as needed. This form must be provided at the same time as the *CACFP Meal Benefit Income Eligibility* form, and as requested.

Make additional copies as needed or download Form H1625-A by accessing the Texas Department of Agriculture (TDA) website at http://www.squaremeals.org.

Form Retention

Keep Form H1625-A for three years from the end of the program year. **Exception:** If audit findings, claims or litigation have not been resolved by the end of the retention period, all forms and records must be retained until all issues are resolved.

Income Eligibility Guidelines for Determining Free and Reduced-Price Benefits July 1, 2016 - June 30, 2017

Ingresos máximos para determinar la elegibilidad para el programa de nutrición 1 de julio de 2016 - 30 de junio de 2017

FAMILY SIZE	ANNUAL REDUCED	MONTHLY REDUCED	TWICE MONTHLY REDUCED	BI-WEEKLY REDUCED	WEEKLY REDUCED
1	$21,978	$1,832	$916	$846	$423
2	$29,637	$2,470	$1,235	$1,140	$570
3	$37,296	$3,108	$1,554	$1,435	$718
4	$44,955	$3,747	$1,874	$1,730	$865
5	$52,614	$4,385	$2,193	$2,024	$1,012
6	$60,273	$5,023	$2,512	$2,319	$1,160
7	$67,951	$5,663	$2,832	$2,614	$1,307
8	$75,647	$6,304	$3,152	$2,910	$1,455
For each additional family member add:	$7,696	$642	$321	$296	$148

Children from households whose incomes are at or below the levels shown above, 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 above, or who receive Medicaid, Supplemental Security Income (SSI) or SNAP benefits, are eligible for free or reduced-price meals.

Los niños de hogares con ingresos iguales o menores a los niveles indicados anteriormente, 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 indicados anteriormente, 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.

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 case number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits.
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 a case 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.

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, 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 toll free: **1-866-USDA CND**
(1-866-873-2263)

Visit USDA's website: **www.fns.usda.gov/cnd**

USDA
United States Department of Agriculture
Food and Nutrition Service
FNS-317
June 2000
Revised June 2001

Construyendo Para El Futuro

Esta guardería infantil recibe
asistencia monetaria del gobierno federal
para servir comidas nutritivas a sus niños.
¡Buena nutrición hoy significa
un mañana más saludable!

Comidas servidas aquí deben de seguir los
requisitos nutricionales establecidos por el programa
"Child and Adult Care Food Program"
del Departamento de Agricultura de los Estados Unidos
(USDA por sus siglas en inglés).

¿Preguntas? ¿Inquietudes?

Llame gratuitamente a USDA al: **1-866-USDA CND**
(1-866-873-2263)

Visite el website de USDA: **www.fns.usda.gov/cnd**

USDA
United States Department of Agriculture
Food and Nutrition Service
FNS-317-S
June 2000
Revised June 2001

Texas WIC Reference Guide

Purpose of WIC

To give children the best possible start by providing optimal nutrition during the critical stages of development.

Who is Eligible?

Pregnant Women
Breastfeeding Women
Postpartum Women
Infants
Children younger than 5

Eligibility Requirements

Meet income guidelines.
(see chart below)
Households with incomes up to 185% of the federal poverty line are eligible.

Have a nutrition-related health problem.
WIC applicants receive an initial screening at a WIC clinic to find any nutrition problems.

Be a resident of Texas.
WIC clients usually receive services in the county where they reside.
U.S. citizenship is not a requirement for eligibility.

Income Eligibility Guidelines

effective April 1, 2004

Number of Household Members*	Gross Monthly Household Income	Gross Yearly Household Income
1	$0 up to $1,436	$0 up to $17,224
2	$0 up to $1,926	$0 up to $23,107
3	$0 up to $2,416	$0 up to $28,990
4	$0 up to $2,907	$0 up to $34,873
5	$0 up to $3,397	$0 up to $40,756
6	$0 up to $3,887	$0 up to $46,639

For more than 6 household members, or if you have any income questions, call 1-800-942-3678. Individuals with proof of Medicaid, TANF, or Food Stamps automatically meet income eligibility.

**One pregnant woman counts as two household members.*

Call
1-800-942-3678

WIC GROWING HEALTHY FAMILIES

ProtectTexas™
Texas Department of Health

13-55 Revised 4/04

How to Become a WIC Client

Call 1-800-942-3678. You'll get the phone number of the best WIC clinic for you.

Call that clinic. Make an appointment to see if you and/or your household members can become WIC clients.

Bring proof of income.

Anyone on Medicaid, TANF, or Food Stamps already has the right income for WIC. So, bring proof that you and/or your household members are on Medicaid, TANF, or Food Stamps.

For each person in your house who has income, bring one of these items:

- Pay stub that shows "gross income."
- Current tax records.
- Letter from employer.
- Proof of Social Security benefits.
- Alimony or child-support payments.
- Other proof (check with clinic).

Bring proof of where you and/or your household members live.

Bring one of these items:

- Rent receipt.
- Utility bill.
- Other proof (check with clinic).

Bring proof of identification for each person who wants WIC benefits.

Bring one of these items:

- Driver's license.
- Birth certificate.
- School ID or work ID.
- Other proof (check with clinic).

Each woman, infant, and child who wants WIC benefits must come to the appointment.

You each will get a simple screening to find any nutrition problems.

Services WIC Offers

Nutrition Education

Nutrition counseling
Nutrition classes

Breastfeeding Support and Education

Clients receive encouragement and instruction in breastfeeding methods.

You may be eligible for a breast pump from WIC.

WIC foods

Milk, Buttermilk Cheese
Cereals Juices
Eggs Beans, Peas, Lentils
Peanut butter Infant formula

For breastfeeding mothers only:
Tuna Carrots

Childhood Immunizations

Some WIC clinics give shots. Others will refer you to a nearby shot clinic.

Referrals

WIC refers to a variety of health and social services, including:

Medicaid and Texas Health Steps
Family Planning
Head Start
TANF and Food Stamps
Early Childhood Intervention
Children's Health Insurance Progam (CHIP)

Bay Area Child Development Center, Inc.'s
Addendum to Parent Handbook
October 2014-Sept 2015

TWC-CCS Parent Fees

Parent fees are due on the 1st of each month. A $5.00 per day late fee will be charged for payments not received on the 1st working day of each month. Fees not paid in full, risk the availability of your child's space at the center. These fees are required to ensure that the center is following its agreement with the Texas Workforce in that parent fees must be collected in advance of provided childcare. There will be no exceptions. All parents must use their cards to sign their child/ren in, if you forget to sign your child in you will be responsible for paying for the days that Texas Workforce does not pay the center for. You will be billed your daily rate plus late fees. PLEASE NOTE THAT ANY CHILD RECEIVING TEXAS WORKFORCE CHILDCARE SERVICES MUST SIGN IN/OUT USING THEIR CARD ON A DAILY BASIS. CARE IN THE CENTER FOR FULL-TIME STUDENTS MEAN THEIR POSITION AT THE CENTER IS HELD FOR THEM ALL 5 DAYS OF THE WEEK. IN THE CASE THAT YOUR CHILD IS ABSENT, NOT SIGNED IN OR ILL, IT IS YOUR SOLE RESPONSIBILTY TO SIGN THEM IN FOR THE DAY IN ORDER FOR THE WORKFORCE PROGRAM TO PAY FOR THAT PARTICULAR DAY. ANY DAYS NOT PAID BY THE TEXAS WORKFORCE CHILDCARE SERVICES, WILL BE YOUR SOLE RESPONSIBILITY TO PAY PRIVATELY. THOSE CHARGES WILL BE ADDED TO PARENT FEES AND WILL BE PAID BEFORE PAYMENT IS APPLIED TO PARENT FEES AS IS LATE FEES FOR PAYMENTS NOT RECEIVED ON THE 1ST. NON-PAYMENT OF ANY FEES CHARGED TO THE PARENT OR TEXAS WORKFORCE LEFT UNPAID WILL RESULT IN CHILDCARE SERVICES AT THIS CENTER OR ANY OTHER CENTER BEING SUSPENDED UNTIL YOUR ACCOUNT IS PAID IN FULL. OUR CENTER WORKS CLOSELY WITH TEXAS WORKFORCE IN ORDER TO PROVIDE OUR PARENTS AND CHILDREN WITH CHILDCARE ABOVE AND BEYOND THE MINIMUM REQUIREMENTS OF THE STATE AND THERFORE MUST PROTECT ITS INTEREST IN GETTING PAYMENTS TIMELY AND ENSURING THAT EACH DAY THE CHILD SPOT IS BEING HELD FOR IS PAID ACCORDINGLY.

I have received the above addendum and understand that this new policy is in force immediately.

_____ Date: _____

Parent Signature

NOTICE TO PARENTS:

We here at Bay Area Child Development Centers Inc. want each and every parent to feel welcome. For those parents of Infants that are breast feeding, you are welcome at anytime throughout the day to come and bond with your child. For those who can't, we provide refrigerators in each of our infant rooms so that you may pump and store it here at the facility for daily use. If you have any questions regarding breastfeeding here at the center please feel free to ask your Child's teacher or Center Director.

Bay Area Child Dev. Center

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

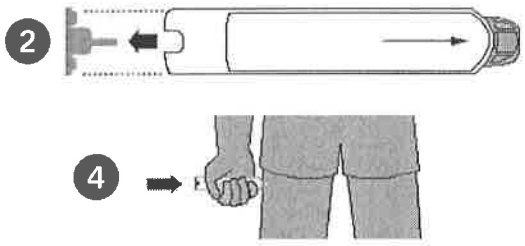
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016