

# Little Folks Farm & Childcare

## Parents Information Page

\*Owner/ Director : Lisa Davis

\*Assistant Director : Amery Morgan

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\*Phone: Lisa 912-454-0249

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\*Facebook : Little Folks Farm and Childcare

\*Website: [Littlefolksfarm.com](http://Littlefolksfarm.com)

\*Physical address for center: 1392 Ga, Hwy. 56 East

Lyons, Ga. 30436

\*Hours of operation: 6:00 am till 6:00 pm

\*Days and months of operation: Monday thru Friday

January thru December

\*We care for children aged six weeks through after school children aged 13 yrs.

\*The bus picks up at 6:45 am and brings kids back from school at 3:15 pm from Toombs Central Elementary school, Route 23.

\*We participate in the childcare network food program and are monitored during meal or snack times. This means that we must serve balanced meals & Snacks and must keep a clean environment along with other Department of Public Health and USDA Rules and Regulations.

\* We serve Breakfast, Lunch and pm snack every day.

\* The menu will be posted beside the sign in/Out sheets each day.

\* If your child has such food allergies that they are at risk of anaphylactic shock, break outs, etc. You will need to pack their food for the day to be brought in each morning. We would rather be on the safe side and have parents bring the child's food from home to keep accidents from happening as much as possible. After all, parents know best.

**\*We accept the CAPS program, here is how to apply.**

**The Childcare and Parent Services (CAPS) program assists low-income families with the cost of childcare in Georgia<sup>1</sup>. To apply for the CAPS program online, you can follow these steps:**

1. Visit the Georgia Gateway website<sup>1</sup>.
2. Log in or create an account.
3. Select "Childcare" from the list of assistance programs.
4. Follow the prompts to apply for CAPS.
5. A CAPS staff member will call you to review your application and determine eligibility<sup>1</sup>.

**You will need to redetermine your eligibility for CAPS each year (known as annual redetermination)<sup>1</sup>. A Family Support Consultant can help you with this process<sup>1</sup>**

**Payments:**

Full time \$125 per week

Full time Infants \$150 per week

Daily Rate (up to three days) \$35.00 per day

**(We must know in advance when your child will be here)**

After school \$75.00 per week

**\*The week of July 4<sup>th</sup> and the last week of the year are the two weeks per year that we do not charge for. We are closed these two weeks.**

**And by Cash or check**

**\*Payment is accepted through our website. And through Venmo @Lisa-Onthefarm56**

**\*There will be a 40.00 charge on all returned checks.**

**\*Payments have always been due on Mondays at the beginning of the childcare week.**

**\*A \$5.00 late fee will be added for each day after Monday.**

**\* Extremely Important!!**

**\*If you have a phone number or address change, please let us know immediately so we can change it in your child's file.**

\* If someone new comes to pick up your child and we have not met them, we will need to hear from you first. We can not release a child to someone we do not know and who is not listed in your child's file. They must bring in a driver's license/ picture I.D.

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**I have read and understand all of what I have read.**

**I have asked questions I understand that childcare is a commitment of two parties, the parents and the care provider. This means that we both must keep open communication, this is the best policy.**

**Lisa Davis**

# CHILDREN'S ENROLLMENT FORM

Entrance Date \_\_\_\_\_ Withdrawal Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Home Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Father's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Mother's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child's Living Arrangements: (check one)  Both Parents  Mother  Father  Other

Child's Legal Guardian(s): (check one)  Both Parents  Mother  Father  Other

The child may be released to the person(s) signing this agreement or to the following:

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)  
Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Relationship to Parent(s) or Guardian \_\_\_\_\_  
Other identifying information (if any) \_\_\_\_\_

\*Name \_\_\_\_\_ Address \_\_\_\_\_  
(Street-City-State-Zip)  
Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Relationship to Parent(s) or Guardian \_\_\_\_\_  
Other identifying information (if any) \_\_\_\_\_

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name of Public or Private School child attends, if any: \_\_\_\_\_

Child's doctor or clinic name \_\_\_\_\_

Doctor/clinic phone # \_\_\_\_\_

My child has the following special needs \_\_\_\_\_

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: \_\_\_\_\_

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**

Should (child's name) \_\_\_\_\_ Date of birth \_\_\_\_\_  
suffer an injury or illness while in the care of (Facility name) \_\_\_\_\_  
and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention  
and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

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

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

**Facility Administrator/Person-In-Charge** \_\_\_\_\_  
Signature

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

### Parental Agreements with Child Care Facility

The \_\_\_\_\_ agrees to provide child care for  
 \_\_\_\_\_  
 (Name of Facility)  
 \_\_\_\_\_ on \_\_\_\_\_ a.m. to \_\_\_\_\_ p.m.  
 (Name of Child) (Days of Week)  
 from \_\_\_\_\_ to \_\_\_\_\_  
 (Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

- Breakfast
- Morning Snack
- Lunch
- Afternoon Snack
- Evening Snack
- Dinner
- Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The \_\_\_\_\_ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for

\_\_\_\_\_  
(Name of Facility)

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Facility Administrator/Person-In-Charge)

**Bright from the Start: Georgia Department of Early Care and Learning**

**Child Adult Care Food Program**

**Income Eligibility Statement**

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

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

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

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

My child is normally in attendance at the facility between the hours of \_\_\_\_\_ [am/pm] to \_\_\_\_\_ [am/pm] on the following days:  
 Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:  
 (Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

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

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

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

Signature: X \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: GA Zip \_\_\_\_\_ Phone \_\_\_\_\_

Last four Digits of Social Security Number XXX-XX \_\_\_\_\_  I do not have a Social Security Number

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

Mark one ethnic identity: <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Not Hispanic/ Latino	Mark one or more racial identities: <input type="checkbox"/> Asian <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
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**Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12**

Total income: \_\_\_\_\_ Per:  Week  Every 2 weeks  Twice a month  Month  Year Household Size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_\_ Date withdrawn \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Paid \_\_\_\_\_ Tier I \_\_\_\_\_ Tier II \_\_\_\_\_

Temporary: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_\_\_ days)

Determining Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Follow Up Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

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

Household Size	Yearly Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

this

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [https://www.ascr.usda.gov/complaint\\_filing\\_cust.html](https://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.



Name of Sponsor (if applicable) Childcare Network

Name of Provider/Center Little Folks Farm & Childcare

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program I must offer to provide meals to all infants enrolled for care in my center/facility.

I will provide \_\_\_\_\_ and \_\_\_\_\_ to  
Milk- based iron-fortified formula Iron fortified infant cereal

Infants enrolled for care in my facility.

**Parents/Guardians, please check one of the following options and sign this form:**

\_\_\_\_\_ I would like the provider/center to provide the milk-based iron-fortified infant formula and iron-fortified infant cereal listed above to my infant and I will provide clean, sanitized, and labeled bottles daily.

I will provide \_\_\_\_\_ and \_\_\_\_\_  
Milk- based Iron-fortified formula

\_\_\_\_\_ for my infant on a daily basis.  
Iron-fortified cereal

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

\_\_\_\_\_  
Date

\*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian although the center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.