FRIENDSHIP HOUSE, INC.
PRE-ENROLLMENT FORM
1300 S. HAMILTON STREET P.O. BOX 794
DALTON, GA 30722-0794
(706) 278-8012
(FAX) (706) 275-8878

CHILD'S NAME:_____ AGE:____ BIRTHDAY: / / GENDER (F) (M)
NOMBRE DEL NINO: EDAD FECHA DE NACIMENTO SEXO

ADDRESS:_____
NUMBER STREET CITY ZIP PHONE
DIRECCION: NUMERO CALLE CIUDAD CODIGO POSTAL

MOTHER (GUARDIAN):_____ RELATIONSHIP:_____
MADRE (GUARDIAN) PARENTESCO

EMAIL ADDRESS:_____

EMPLOYER:_____ WORK PHONE:_____ EXT:_____
EMPLEO TELEFONE DEL TRABAJO EXTENCCION

FATHER (GUARDIAN):_____ RELATIONSHIP:_____
PADRE PARENTESCO

EMPLOYER:_____ WORK PHONE:_____ EXT:_____
EMPLEO TELEFONE DEL TRABAJO EXTENCCION

MARITAL STATUS: ( ) MARRIED ( ) DIVORCED ( ) WIDOW ( ) OTHER:_____
ESTADO CIVIL: CASADO DIVORCIADO VIVDA OTRO

PERSON THAT MAYBE CALLED IF WE CANNOT REACH YOU BY PHONE
PERSONA QUC PODAMOS ILAMAR NO CONTESTE TU TELEFONO
NAME:_____ RELATIONSHIP:_____
NOMBRE:_____ PARENTESCO:_____
WORK PHONE:_____ HOME PHONE:_____
TELEFONE TRABAJO:_____ CASA TELEFONE:_____

HAS YOUR CHILD EVER ATTENDED FRIENDSHIP HOUSE? YES ( ) NO ( )
TU, NINO HA ESTADO AQUI ANTES? SI ( ) NO ( )

HOW DID YOU LEARN ABOUT THIS CHILD CARE CENTER?
( ) FRIEND ( ) RELATIVE ( ) TELEPHONE BOOK ( ) OTHER:
QUIN TE INFORMO ACERCA DE ESTE LUGAR?
( ) AMIGO ( ) PARIENTE ( ) LIBRO DE TELEFONO ( ) OTRO:

PARENT/ GUARDIAN SIGNATURE:_____
FIRMA PARIENTE O GUARDIAN:

DATE: /_____/_____ OFFICE USE ONLY: COMMENTS: _____
FECHA: /_____/_____ PARA USO DEFICINA: _____
_____

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-

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

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

PART III: ENROLLMENT INFORMATION: Children Only

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

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

(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:	Mark one or more racial identities:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

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

Total Income: _____ Per: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year Household Size: _____

Categorical Eligibility: _____ 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_____