

# Welcome to the Limitless Family!★

Limitless Pediatric Solutions is a bilingual team of therapists, teachers and interpreters that enhance hands-on-learning with love and respect. Our inclusive programs include the services of Childcare, Therapy and Interpreting. All of our programs are designed to provide a unique and exceptional educational experience for all of our little ones. Limitless prides themselves on promoting social and cultural diversity. The environment tailors each child's needs to ensure everyone receives the support they need!!!

Thank you for allowing us to be part of your exciting journey!

## New Enrollment Appointment Checklist

Name of parent: \_\_\_\_\_

Name of student: \_\_\_\_\_

Today's Date: \_\_\_\_\_

- CALENDAR (for Parents)

-----  
-For Office use only to create a file-

### To file to the Right

- Immunization Records (DHEC Form 4024)
- REGISTRATION- DSS FORM 2900
- CHILD'S HEALTH/EMERGENCY CONTACTS FORM 0037
- PARENT POLICIES REVIEWED (see Family Handbook)
- SIGN FAMILY HANDBOOK YEARLY
- RELEASE OF CHILD POLICY
- DISCIPLINE AND MALTREATMENT POLICY

### To file to the Left

- LIMITLESS CONTRACT
- ID pictures of parents and authorized people to pick up
- Insurance Card
- GETTING TO KNOW YOU (CHILD) FORM
- PICTURE AND VIDEO CONSENT FORM
- WAIVER FORM
- COPIES OF CHILD'S IEP, 504, OR LATEST OT/PT/ST EVALUATION

### For separate filling (ABC and CACFP Binder)

- ABC Connection form
- ABC letter of approval
- ABC letter with rate approved
- CACFP Form 16160

**Bluffton Location: 4 Oliver Court, Suite 105. Bluffton. SC. 29910.**

**Phone: 843-706-9367**

**\*Hardeeville Location: 21563 Whyte Hardee Blvd. Hardeeville. SC. 29927.**

**Phone 843-208-6121**

**\*Walterboro Location: 2414 Jefferies Hwy. Walterboro. SC. 29488.**

**Phone: 843-706-9367**

**Limitless Fax: 843-306-4304**

<https://www.limitlesspeds.com/>



limitless Pediatric Solutions



limitlesspediatric



South Carolina Department of Social Services  
Child Care Regulatory Services  
**GENERAL RECORD AND STATEMENT OF CHILD'S HEALTH FOR ADMISSION  
TO CHILD CARE FACILITY**

This form is to be completed for each child at the time of enrollment in the child care facility, updated as needed when changes occur, and maintained on file at the facility.

**GENERAL INFORMATION:** (to be completed by Parent or Guardian)

Name of Facility: \_\_\_\_\_ County: \_\_\_\_\_ Select County ...

Address: \_\_\_\_\_  
Street Address – no Post Office Boxes City, State, Zip

Child's Name: \_\_\_\_\_  
Last First Middle Initial Nick Name

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

Child's Current Home Address: \_\_\_\_\_  
Street Address City, State, Zip

Parent/Guardian's Full Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Parent/Guardian's Full Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**You must have two individuals who have the authority to obtain emergency medical treatment for the child.**

1. Person responsible if parent/guardian unavailable for emergency medical services:

\_\_\_\_\_  
Full Name Relationship  
Address: \_\_\_\_\_  
Street Address City, State, Zip  
Telephone Number(s): \_\_\_\_\_ Family Code Word(s): \_\_\_\_\_

2. Person responsible if parent/guardian unavailable for emergency medical services:

\_\_\_\_\_  
Full Name Relationship  
Address: \_\_\_\_\_  
Street Address City, State, Zip  
Telephone Number(s): \_\_\_\_\_ Family Code Word(s): \_\_\_\_\_

Is Child currently enrolled in school? (5K up to 6 years old) ☐ Yes ☐ No

My Child will regularly attend this facility **FROM** \_\_\_\_\_ am/pm **TO** \_\_\_\_\_ am/pm

If Child is a drop-in, indicate hours of care: **FROM** \_\_\_\_\_ am/pm **TO** \_\_\_\_\_ am/pm

**Check** all days Child will regularly attend this facility: ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

**Check** all meals Child will receive daily: ☐ Meals are not offered ☐ Breakfast ☐ Morning Snack ☐ Lunch  
☐ Afternoon Snack ☐ Dinner ☐ Evening Snack

**HEALTH INFORMATION:** (to be completed by Parent or Guardian)

Family Physician or Health Resource: \_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address City, State, Zip Telephone

Emergency Care Provider: \_\_\_\_\_  
Emergency Facility Name

\_\_\_\_\_  
Street Address City, State, Zip Telephone

Dental Care Provider: \_\_\_\_\_  
Name

Street Address City, State, Zip Telephone

Health Insurance Provider: \_\_\_\_\_

Certificate of Immunization: ☐ Yes ☐ No ☐ N/A Please explain: \_\_\_\_\_

**My child has the following health conditions such as allergies, asthma, diabetes, epilepsy, etc., and/or takes the following medications on a regular basis:**

Additional Comments: \_\_\_\_\_

I certify that to the best of my knowledge \_\_\_\_\_  
Child's Name

is in good mental and physical health and able to participate in the child care program at

\_\_\_\_\_  
Name of Child Care Facility

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Director/Operator/Staff Designee

**Child's Health/Emergency Information and Authorization Form  
for Transportation Providers**  
(To be completed by the child's parent or guardian)

**Health/Emergency Information**

Child's Name: \_\_\_\_\_

Other Name Child Responds to (if applicable): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent's/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: (     ) \_\_\_\_\_

Workplace: \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

Address where child is to be picked up and returned (if different from above): \_\_\_\_\_

Person(s) responsible for meeting child being transported: \_\_\_\_\_

**In case of emergency and the parent(s)/guardian(s) cannot be reached, please contact one of the following persons:**

1)	Name: _____	Phone: (     ) _____
	Address: _____	Relationship: _____
2)	Name: _____	Phone: (     ) _____
	Address: _____	Relationship: _____

Please give specific instructions if your child needs special assistance, equipment, or materials when transported.

List any chronic medical condition or allergies your child may have as well as any medications your child may take:

Other important information about your child: \_\_\_\_\_

**Authorization for Transportation Services**

I authorize the following transportation provider \_\_\_\_\_ to  
transport my child to and from the following location \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Authorization for Emergency Medical Care**

In case of accident or illness requiring medical attention, the undersigned authorize \_\_\_\_\_ (transportation provider) to call a health care provider or to take my child \_\_\_\_\_ (child's name) to the nearest hospital or doctor, and it is understood that if possible, their services will be obtained. If neither parents nor preferred health care provider can be contacted, the transportation provider is authorized to contact another health care provider. It is also understood that this agreement covers only those situations, which in the best judgment of the transportation provider, are true emergencies.

**The health care provider to call is: My hospital preference is:**

Name: _____	Name: _____
Address: _____	Address: _____
Phone: (     ) _____	Phone: (     ) _____

I authorize emergency treatment deemed necessary by a physician in the event that I cannot be reached for permission. I agree to be responsible for the cost of such emergency medical care.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

DCD-0037  
11-11-11



Name\_\_\_\_\_

### POLICIES REVIEW

By signing below, I acknowledge I have read, reviewed, received and understand the Limitless Pediatric Solutions Policies which include the following:

\*\* All questions have been answered as needed by the Child Care Director.

- Release of Child
- Medication
- Emergency Medical Care
- Discipline and Maltreatment
- Incidents and Behavior Management
- Child Abuse and Neglect
- Confidentiality
- Tracking Children
- Transportation
- Prevention and Control of Infectious Disease
- Handling, Storage, and Disposal of Hazardous Materials and Biological Contaminants
- Liability Insurance
- Provisional Employment
- Parental Access
- Waiver Form
- Picture and Video Consent Form
- Mental Health
- Nutrition
- Transitions
- Outdoor
- Screening
- Swimming

Signature\_\_\_\_\_1st year Date\_\_\_\_\_

Signature\_\_\_\_\_2nd year Date\_\_\_\_\_

Signature\_\_\_\_\_3rd year Date\_\_\_\_\_

Signature\_\_\_\_\_4th year Date\_\_\_\_\_

Signature\_\_\_\_\_5th year Date\_\_\_\_\_

Signature\_\_\_\_\_6th year Date\_\_\_\_\_



Limitless Pediatric Solutions  
Family Handbook

**Contact information:**

License # 25097  
Director- Janine Namdar  
4 Oliver Court Suite 105  
Bluffton SC 29910  
Phone 843 706-9367

License # 25486  
Director-Tonya Jenkins  
21563 Whyte Hardee Blvd.  
Hardeeville SC. 29927  
Phone 843-208-6121

Fax 843 306-4304

info@limitlessped.com

**Addendums:**

LPS Discipline and Maltreatment 07/04/2024

Incidents and Behavior Management 07/04/2024

Medication 06/01/2024

Emergency Medical Care 06/01/2024

Inclusion/Non-Discrimination 05/01/2022

Outdoor 07/04/2024

Screening 05/01/2022

Mental Health 07/04/2024

Provisional Employment 05/01/2022

Nutrition 12/16/2022

Transitions 07/04/2024

Discipline and Maltreatment 06/01/2024

Child Abuse and Neglect 06/01/2024

Prevention and Control of Infectious Disease 06/01/2024

Handling, Storage & Disposal of Hazardous Materials & Biological Contaminants 06/01/2024

Parental Access 06/01/2024

Outdoor 06/01/2024

Screening 06/01/2024

Swimming 06/01/2024

I acknowledge that I have received a copy of the Limitless Pediatric Solutions Family Handbook, which contains vital information on the Company's policies and procedures.

I understand that the Company may change its policies, procedures, and benefits at any time at its sole discretion, as well as interpret or vary them however it deems appropriate.

I have reviewed, been informed, read, understand and agree with the Limitless Pediatric Solutions Family Handbook.

Print Name:\_\_\_\_\_ Signature:\_\_\_\_\_ Date 1st year:\_\_\_\_\_

Print Name:\_\_\_\_\_ Signature:\_\_\_\_\_ Date 2nd year:\_\_\_\_\_

Print Name:\_\_\_\_\_ Signature:\_\_\_\_\_ Date 3rd year :\_\_\_\_\_

Print Name:\_\_\_\_\_ Signature:\_\_\_\_\_ Date 4th year :\_\_\_\_\_



## Release of Child Policy

Child Name \_\_\_\_\_ DOB \_\_\_\_\_

**Allergies** \_\_\_\_\_ **Sensitivities** \_\_\_\_\_

Parent/Guardian Full name \_\_\_\_\_

Ph. Number \_\_\_\_\_ Email \_\_\_\_\_

Parent/Guardian Full name \_\_\_\_\_

Ph. Number \_\_\_\_\_ Email \_\_\_\_\_

Please list below **at least two contacts** who will be authorized to pick up your child in case of an emergency, when parent/guardian is unavailable/unreachable or for preplanned pick up.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Ph. Number \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Ph. Number \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Ph. Number \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Ph. Number \_\_\_\_\_ Address \_\_\_\_\_

Please list anyone you wish NOT to pick up your child. If you do Not want the other parent to pick up, legal documents will be requested.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

LPS must be made aware of any changes to your child's pick up information. ID will be required upon your child's release. Password must be given for your child to be released. Please provide a password to be utilized \_\_\_\_\_

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



## Discipline and Maltreatment Policy

### Definitions:

Corporal Punishment-Corporal punishment is the use of physical force to the body as a discipline measure. Corporal punishment is physical force to the body that includes but is not limited to:

Spanking, Slapping, Biting, Shaking, Jerking children by the arms, Dragging children by their legs, Pinching, Hitting, Kicking, Shoving, Hair pulling, Ear pulling.

**\*\*SC Child Care Licensing Law prohibits the use of corporal punishment on any child in a child care setting.**

This includes the owner and employees whose child(ren) is enrolled in the program, and any parent of an enrolled child who might discipline their child before leaving the premises of the program.

Child Maltreatment includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher). There are four common types of abuse. They are sexual, physical, emotional and neglect.

The following are examples (but not limited to) of abuse and neglect that may occur in a child care setting: Physical harm, Withholding food, Withholding water, Withholding restroom use, Verbally threatening a child, Yelling at a child, Shaming, Inappropriate discipline such as washing a child's mouth out with soap.

### Policy:

Limitless Pediatric Solutions prohibits the use of corporal punishment and maltreatment of children by staff regardless of the type of relationship the employee has to the child. The program provides employees with behavioral strategies and support through training and technical assistance that promotes positive guidance practices. **Staff, read, agree, and implement the policy, which is signed annually.**

Limitless Pediatric Solutions provides a wide assortment of training every month to promote positive guidance practices to children, some of the courses included are The Alert Program, to help regulate emotions, Introduction to Infant Mental Health Training 101, Welcoming Dual Language Learners Into Your Class, and Responsive Care through Play. We have in place LPS standards for teaching, where we establish intentional teaching practices and standards, among those responsive, sensitive care, and guidance.

Limitless Pediatric Solutions provides a non-exhaustive list of strategies to support children's behavior that includes the following: Communicate to children using positive statements in a calm, quiet manner. Explain unacceptable behavior, give attention to children for positive behavior, praise and encouragement, reason with and set limits for the children, using The Wilbarger Deep Pressure and Proprioceptive Technique (DPPT), sensory diets, behavior tracking forms, giving positive reinforcement, etc. We have a process of recording behaviors and incidents in log sheets, arrange meetings with teachers, parents, directors, and therapists and plan to come up with solutions to different behaviors and implement them into daily activities.

In combination with this, Limitless Pediatric Solutions also works with the following outside agencies to provide technical assistance related to positive guidance strategies to staff: CCR&R, SC Inclusion Collaborative, SCIMHA, Babynet, First Steps, No child Left Behind, Pear partners, Family Connection, HIPAA Beaufort County Disabilities Coalition, ABC Quality, PASOS, South Carolina Program for Infant/Toddler Care, among others.

Limitless Pediatric Solutions, staff have been reviewed, informed, read, understand, and agree to implement/abide by the Discipline and Child Maltreatment policy as written. Our program understands that non-compliance with this policy can result in adverse actions.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date 1st year: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date 2nd year: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date 3rd year: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date 4th year: \_\_\_\_\_



## GETTING TO KNOW YOU FORM

We would like to know more about your child, the more information you provide, the better we can work to meet your child's needs. Please answer the questions from your point of view. Thank you!

Today's Date \_\_\_\_\_ Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Allergies: \_\_\_\_\_ Sensitivities: \_\_\_\_\_

Parent Completing Form \_\_\_\_\_ Contact # \_\_\_\_\_

What motivates your child?: \_\_\_\_\_

Describe your child's character in 3 to 5 words: \_\_\_\_\_

What are your child's strengths? \_\_\_\_\_

What concerns do you have? \_\_\_\_\_

What goals do you have for your child this year? \_\_\_\_\_

What do you do to regulate your child's emotions? \_\_\_\_\_

### Family Background

Is your child an adopted or foster child? ☐ Yes ☐ No Place of Birth \_\_\_\_\_

Who lives in your home?

Name	Relationship to Child	Age

Language(s) spoken at home \_\_\_\_\_ Primary Language \_\_\_\_\_

Please describe in your words what your child and family's routine looks like \_\_\_\_\_

Hobbies Enjoyed \_\_\_\_\_

Please list any activities your child enjoys \_\_\_\_\_

Please list any activities your child dislikes \_\_\_\_\_

Wake time \_\_\_\_\_ Sleep time \_\_\_\_\_ Nap time \_\_\_\_\_

### School Background

Is your child coming from another school? ☐ yes; School Name \_\_\_\_\_ ☐ No

Please describe the reason for changing schools \_\_\_\_\_

How did you learn about us? \_\_\_\_\_

### Medical Background

Vision tested ☐ yes Date \_\_\_\_\_ ☐ No Hearing tested ☐ yes Date \_\_\_\_\_ ☐ No

Does your child use any adaptive equipment (glasses, hearing aids, weighted vest, etc.) ☐ yes ☐ No

Does your child have any medical diagnosis? If so, please explain \_\_\_\_\_

Would you be open to a medical/therapy referral if not completed yet? \_\_\_\_\_

Allergies? \_\_\_\_\_

Sensitivities? (ie. diarrhea for milk) \_\_\_\_\_

\*\*Please provide Dr. documentation for allergies/sensitivities.

- Toilet trained
- Able to brush hair
- Helps with dressing (shirt, pants, socks, shoes)
- Able to wash hands
- Able to brush teeth
- Able to manipulate clothing fasteners: buttons, zipping, snaps, shoelaces
- Able to feed using spoon, fork, fingerfeed
- Able to drink from bottle, sippy, open cup

- How many bottles per day? \_\_\_\_\_ Times \_\_\_\_\_
- Is your child on a special diet? If so explain \_\_\_\_\_

Any feeding precautions?(ie. Gagging, choking, etc) \_\_\_\_\_  
 How many meals a day? \_\_\_\_\_ Times \_\_\_\_\_

**Temperament and Social Emotional Needs**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Attentive   | <input type="checkbox"/> Hyperactive/Underactive             | <input type="checkbox"/> Elopement risk                            |
| <input type="checkbox"/> Prefers to play alone/<br>withdrawn                     | <input type="checkbox"/> Shows Safety Awareness              | <input type="checkbox"/> Impulsive/Restless                        |
| <input type="checkbox"/> Confused in noisy places                                | <input type="checkbox"/> Self Abusive Behavior               | <input type="checkbox"/> Inappropriate Behavior                    |
| <input type="checkbox"/> Requests things or starts<br>New activities with others | <input type="checkbox"/> Cooperative                         | <input type="checkbox"/> Separation Difficulties                   |
| <input type="checkbox"/> Destructive/Aggressive                                  | <input type="checkbox"/> Demands Attention                   | <input type="checkbox"/> Lacks Confidence                          |
| <input type="checkbox"/> Makes inappropriate<br>Statements                       | <input type="checkbox"/> Lacks Motivation                    | <input type="checkbox"/> Stubborn                                  |
| <input type="checkbox"/> Nervous/Sensitive                                       | <input type="checkbox"/> Talks excessively                   | <input type="checkbox"/> Difficulty Eating                         |
| <input type="checkbox"/> Able to express<br>wants/needs                          | <input type="checkbox"/> Easy Transitions                    | <input type="checkbox"/> Poor Eye Contact                          |
| <input type="checkbox"/> Plays alone for a<br>Reasonable length of time          | <input type="checkbox"/> Poor Safety Awareness               | <input type="checkbox"/> Hard Transitions                          |
|  | <input type="checkbox"/> Unusual body movements/<br>Gestures | <input type="checkbox"/> Easily Distracted/Short<br>Attention Span |
|  | <input type="checkbox"/> Easily Frustrated                   | <input type="checkbox"/> Plays well with Playmates                 |
|  | <input type="checkbox"/> Easily Managed at Home              | <input type="checkbox"/> Willing to try new activities             |

**Any Current Services Received**

Please check all services your child has received/is currently receiving

- ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Behavior Therapy

Does your child have a behavior plan in place? \_\_\_\_\_

Does your child require any special accommodations? \_\_\_\_\_

Is your child currently enrolled in the Early Intervention Program-Baby net? \_\_\_\_\_

Was enrolled? \_\_\_\_\_ Agency Name \_\_\_\_\_ County \_\_\_\_\_

Service Coordinator/Early interventionist \_\_\_\_\_ Phone # \_\_\_\_\_

Is your child currently receiving school-based services? \_\_\_\_\_ If so, Therapist \_\_\_\_\_

Phone # \_\_\_\_\_ School \_\_\_\_\_

Do you give permission for Limitless Pediatric Solutions LLC, to contact the school for therapy related information? \_\_\_\_\_

We offer free Developmental Screenings for Speech, Physical and Occupational Therapy Services for children. Screenings are used to determine if your child would benefit from our services to help them reach developmental milestones in ALL aspects of their life, to maximize their daily independence. Areas we work on include but are not limited to:

- Handwriting
- Self Care and Hygiene training
- Age-appropriate behaviors
- Sensory Processing
- Exploiting and maximizing play and leisure.

Please sign here if you DO NOT want your child screened \_\_\_\_\_

Use the following space to let us know your areas of concern or comments. \_\_\_\_\_

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



## Picture & Video Consent Form

I, \_\_\_\_\_ consent to have pictures and videos of my child \_\_\_\_\_ taken while attending Limitless Pediatric Solutions LLC. These pictures and videos may be used at the discretion of Limitless Pediatric Solutions LLC with my consent. This will include posting on social media such as Facebook, Instagram, Tik Tok and Whatsapp.

I, \_\_\_\_\_ DO NOT give consent to have pictures and videos of my child \_\_\_\_\_ taken while attending Limitless Pediatric Solutions LLC.

I give Limitless Pediatric Solutions LLC consent to take pictures and videos of my child for Whatsapp for the purpose of parent-teacher communication.

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

## Waiver Form

During my participation with Limitless Pediatric Solutions, I acknowledge and agree to the following:

- That my participation in Limitless Pediatric Solutions is voluntary and at will..
- I knowingly assume any and all risks and damage or injury while on Limitless Pediatric Solutions Property.
- I take responsibility for my participation and activities while I am not on premise.
- In consideration for being a volunteer, I hereby release, waive and forever discharge and covenant not to sue Limitless Pediatric Solutions LLC, and it's owner, agents, employees, officers, and all other persons or entities acting on its behalf from any and all claims, actions, damages, liability, cost or expense, including attorney's fees, which are related to or arise out of or are in any way connected to my participation or use of the entire facility.
- By the execution of the agreement, it is my intention to assume any risk of injury, disability and do hereby surrender and waive any rights to sue or exercise any legal right to seek damages against Limitless Pediatric Solutions, LLC, its owners, agents, employees, officers and/or entities acting on its behalf.
- Limitless Pediatric Solutions is not liable for pre-existing or new onset allergy and allergy reactions.
- I hereby certify that I am over 18 years of age. I have carefully read the foregoing covenant and that I understand and agree to all the above terms and conditions.

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

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**If your child has any of the following items please check and attach to this packet.**

- IEP (Individualized Education Plan)
- 504
- Latest Evaluations of OT/PT/ST/Diagnosis report



## SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES CACFP MEAL BENEFIT INCOME ELIGIBILITY (CHILD CARE)

COMPLETE ONE APPLICATION PER HOUSEHOLD. PLEASE USE A PEN (NOT A PENCIL).

**STEP 1** List ALL Household Members who are infants, children, and students up to and including grade 12. (If more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related. Children in Foster Care and children who meet the definition of **Homeless, Migrant or Runaway**, are eligible for free meals.

CHILD'S FIRST NAME	MI	LAST NAME	ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			YES NO	YES NO	YES NO	YES NO
CHILD'S FIRST NAME	MI	LAST NAME	ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			YES NO	YES NO	YES NO	YES NO
CHILD'S FIRST NAME	MI	LAST NAME	ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			YES NO	YES NO	YES NO	YES NO
CHILD'S FIRST NAME	MI	LAST NAME	ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			YES NO	YES NO	YES NO	YES NO
CHILD'S FIRST NAME	MI	LAST NAME	ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			YES NO	YES NO	YES NO	YES NO

**STEP 2** Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF (FI), or FDIPIR?

**IF NO >** Go to STEP 3

**IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

**STEP 3** Total Household Gross Income

Are you unsure what income to include here? Turn to page 3 and review the charts titled, "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section. The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

**A. Child Income**

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often?
	Weekly B-Weekly 2x-Month Monthly
\$	

**B. All Adult Household Members (including yourself)**

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write "0" or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often?	Public Assistance Child Support Allowance	How often?	Pensions/Retirement Social Security/SSI VA Benefits/Other	How often?
	\$		\$		\$	
	\$		\$		\$	
	\$		\$		\$	
	\$		\$		\$	
	\$		\$		\$	

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member

X	X	X	X	X	X				
---	---	---	---	---	---	--	--	--	--

Check if No SSN

**STEP 4** Contact Information and adult signature.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

PRINT NAME OF ADULT SIGNING FORM	SIGNATURE OF ADULT	DATE
ADDRESS	CITY	STATE
	ZIP	PHONE/EMAIL



# SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES CACFP MEAL BENEFIT INCOME ELIGIBILITY (CHILD CARE)

PAGE TWO

## OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of 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) case number or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation

for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL\*: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or  
EMAIL: [program.intake@usda.gov](mailto:program.intake@usda.gov)

\*Only use this address if you are filing a complaint of discrimination.  
This institution is an equal opportunity provider.

## DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income	How often? Weekly Bi-Weekly 2x Month Monthly	Household Size	Eligibility FREE REDUCED FND	For Child Care Homes Only: Tier I _____ Tier II _____
<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	Categorical Eligibility <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Determining Official's Signature	Date	Confirming Official's Signature	Date	



**South Carolina Department of Social Services  
SC Voucher Program**

**CLIENT CONNECTION FORM**

Please complete this form in black or blue ink. Have your provider sign this form and return it. Control Center staff will then notify you and your provider in writing of the start date, fee amount and the provider's billing rate.

Provider Selected:		Provider FEIN/SSN:	
Parent's Name: (First and Last)		Parent's SSN:	
<b>Child's Name (First and Last)</b> List only the child(ren) that have been approved for SC Voucher Program services.	<b>Type of Care Needed (Circle One)</b>		<b>Requested Start Date</b> (Note: This date may not coincide with the approved transfer date.)
	Full-Time	Half-Time	Both
	Full-Time	Half-Time	Both
	Full-Time	Half-Time	Both
	Full-Time	Half-Time	Both
	Full-Time	Half-Time	Both
	Full-Time	Half-Time	Both
	Full-Time	Half-Time	Both
If any of the children attend school, what school district do they attend? (County and district number)			
Parent's Signature:	Date Signed:	Parent's Phone Number: (     )	
Provider's Signature:	Date Signed:	Provider's Phone Number: (     )	

**SOME THINGS TO THINK ABOUT WHEN SELECTING A CHILD CARE PROVIDER**

- Has enough adults to care for all children.
- Allows you to visit at any time and communicates with you regularly.
- Provides a clean and safe environment.
- Provides a variety of age appropriate activities and materials.
- Provides a schedule that allows for nap, and both inside and outside activities.
- Positive interaction between adults and children.
- Listens and is responsive to your needs and concerns.
- Uses positive discipline.
- Child is happy and enjoys going there daily.



Please fax the completed form to: **1-800-310-5417**  
or mail to:

**SC VOUCHER PROGRAM**  
**South Carolina Department of Social Services**  
**P.O. Box 100160**  
**Columbia, SC 29202-3160**  
or email to: **ConnectionForms@dss.sc.gov**



## Limitless Pediatric Solutions Hardeeville Calendar 2025-2026

July 2025							Aug 2025													
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
		1	2	3	4	5						1	2		1	2	3	4	5	6
6	7	8	9	10	11	12	3	4	5	6	7	8	9	7	8	9	10	11	12	13
13	14	15	16	17	18	19	10	11	12	13	14	15	16	14	15	16	17	18	19	20
20	21	22	23	24	25	26	17	18	19	20	21	22	23	21	22	23	24	25	26	27
27	28	29	30	31			24	25	26	27	28	29	30	28	29	30				
Oct 2025							Nov 2025							Dec 2025						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
			1	2	3	4							1		1	2	3	4	5	6
5	6	7	8	9	10	11	2	3	4	5	6	7	8	7	8	9	10	11	12	13
12	13	14	15	16	17	18	9	10	11	12	13	14	15	14	15	16	17	18	19	20
19	20	21	22	23	24	25	16	17	18	19	20	21	22	21	22	23	24	25	26	27
26	27	28	29	30	31		23	24	25	26	27	28	29	28	29	30	31			
							30													
Jan 2026							Feb 2026							March 2026						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
				1	2	3	1	2	3	4	5	6	7	1	2	3	4	5	6	7
4	5	6	7	8	9	10	8	9	10	11	12	13	14	8	9	10	11	12	13	14
11	12	13	14	15	16	17	15	16	17	18	19	20	21	15	16	17	18	19	20	21
18	19	20	21	22	23	24	22	23	24	25	26	27	28	22	23	24	25	26	27	28
25	26	27	28	29	30	31								29	30	31				
April 2026							May 2026							June 2026						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
			1	2	3	4						1	2		1	2	3	4	5	6
5	6	7	8	9	10	11	3	4	5	6	7	8	9	7	8	9	10	11	12	13
12	13	14	15	16	17	18	10	11	12	13	14	15	16	14	15	16	17	18	19	20
19	20	21	22	23	24	25	17	18	19	20	21	22	23	21	22	23	24	25	26	27
26	27	28	29	30			24	25	26	27	28	29	30	28	29	30				
							31													

### LPS Professional Development Days/ 3:00 Pm dismissal:

July 25<sup>th</sup>/ Aug 29<sup>th</sup> /Sept 26<sup>th</sup>/Oct 31<sup>st</sup>/ Nov 21<sup>st</sup>/Dec 19<sup>th</sup> / Jan 30<sup>th</sup> / Feb 27<sup>th</sup> March 27<sup>th</sup> / April 24<sup>th</sup> / May 29<sup>th</sup> / June 26<sup>th</sup>

### Closed/ Holiday/Vacation Days

July 4<sup>th</sup> / July 28<sup>th</sup> –Aug 1<sup>st</sup>/Sept 1<sup>st</sup>/ Sept 4<sup>th</sup>/ Oct 9<sup>th</sup>, 10<sup>th</sup>,13<sup>th</sup>/ Nov 11<sup>th</sup>,12<sup>th</sup>/ Nov 24<sup>th</sup>-28<sup>th</sup>/ Dec 22<sup>nd</sup>- Jan 6<sup>th</sup>/ Jan 19<sup>th</sup>/ Feb 9<sup>th</sup>/ Feb 13<sup>th</sup>/ Feb 16<sup>th</sup>-18<sup>th</sup> / March 23<sup>rd</sup> / April 2<sup>nd</sup> – 3<sup>rd</sup>/ April 13<sup>th</sup>-17<sup>th</sup>/ Apr 29<sup>th</sup>/ May 25<sup>th</sup> June 2<sup>nd</sup>

<p><b>Early Dismissal - 12:30</b> Oct 8<sup>th</sup>/ Dec 19<sup>th</sup> / Feb 12<sup>th</sup> / March 20<sup>th</sup> May 29<sup>th</sup> June 1<sup>st</sup></p>			<p><b>4K</b> Sept 5<sup>th</sup> 4K closed Oct 6<sup>th</sup> to 10<sup>th</sup> Fall Break No school March 6<sup>th</sup></p>			<p><b>4K</b> 1<sup>st</sup> Day of School <b>May 20<sup>th</sup> Graduation</b></p>		
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# Limitless Pediatric Solutions Bluffton Calendar 2025-2026



July 2025							Aug 2025							Sept 2025						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
		1	2	3	4	5						1	2		1	2	3	4	5	6
6	7	8	9	10	11	12	3	4	5	6	7	8	9	7	8	9	10	11	12	13
13	14	15	16	17	18	19	10	11	12	13	14	15	16	14	15	16	17	18	19	20
20	21	22	23	24	25	26	17	18	19	20	21	22	23	21	22	23	24	25	26	27
27	28	29	30	31			24	25	26	27	28	29	30	28	29	30				
Oct 2025							Nov 2025							Dec 2025						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
			1	2	3	4							1		1	2	3	4	5	6
5	6	7	8	9	10	11	2	3	4	5	6	7	8	7	8	9	10	11	12	13
12	13	14	15	16	17	18	9	10	11	12	13	14	15	14	15	16	17	18	19	20
19	20	21	22	23	24	25	16	17	18	19	20	21	22	21	22	23	24	25	26	27
26	27	28	29	30	31		23	24	25	26	27	28	29	28	29	30	31			
							30													
Jan 2026							Feb 2026							March 2026						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	7	1	2	3	4	5	6	7
4	5	6	7	8	9	10	8	9	10	11	12	13	14	8	9	10	11	12	13	14
11	12	13	14	15	16	17	15	16	17	18	19	20	21	15	16	17	18	19	20	21
18	19	20	21	22	23	24	22	23	24	25	26	27	28	22	23	24	25	26	27	28
25	26	27	28	29	30	31								29	30	31				
April 2026							May 2026							June 2026						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
			1	2	3	4						1	2		1	2	3	4	5	6
5	6	7	8	9	10	11	3	4	5	6	7	8	9	7	8	9	10	11	12	13
12	13	14	15	16	17	18	10	11	12	13	14	15	16	14	15	16	17	18	19	20
19	20	21	22	23	24	25	17	18	19	20	21	22	23	21	22	23	24	25	26	27
26	27	28	29	30			24	25	26	27	28	29	30	28	29	30				
							31													

LPS Professional Development Days/ 3:00 Pm dismissal:

July 25<sup>th</sup>/ Aug 29<sup>th</sup> /Sept 26<sup>th</sup> /Oct 31<sup>st</sup>/ Nov 21<sup>st</sup>/ Dec 19<sup>th</sup> / Jan 30<sup>th</sup> / Feb 27<sup>th</sup> March 27<sup>th</sup> / April 24<sup>th</sup> / May 29<sup>th</sup> / June 26<sup>th</sup>

Closed/ Holiday/Vacation Days

July 4<sup>th</sup> / July 30<sup>th</sup> –Aug 5<sup>th</sup>/Sept 1<sup>st</sup>/ Sept 4<sup>th</sup>/ Oct 9<sup>th</sup>, 10<sup>th</sup>/ Nov 11<sup>th</sup>, 12<sup>th</sup>/ Nov 4<sup>th</sup>/ Nov 11<sup>th</sup>/ Nov 26- 28/ Dec 22<sup>nd</sup>- Jan 6<sup>th</sup>/ Jan 19<sup>th</sup>/ Feb 13<sup>th</sup> to 18<sup>th</sup> / March 23<sup>rd</sup> / April 3<sup>rd</sup>/ April 13<sup>th</sup>-17<sup>th</sup>/ May 25<sup>th</sup> / June 1<sup>st</sup> to 3<sup>th</sup> / June 19<sup>th</sup>

Start Day LPS

August 6/ January 6

Early Dismissal - 12:30  
Oct 8<sup>th</sup> / Feb 12<sup>th</sup> / March 20<sup>th</sup>

4K  
Sept 5<sup>th</sup> 4K closed  
Oct 6<sup>th</sup> to 10<sup>th</sup> Fall Break  
Nov 24 to 28 Thanksgiving  
No school March 6<sup>th</sup>

4K  
1<sup>st</sup> Day of School  
January 5 Day of school  
February 17 day of school  
May 20<sup>th</sup> Graduation



## Instructions for Filling Out Placeholder Fields

Please complete the following fields with your personal and school district information:

- [Parent Name] – Your full name
- [Address] – Your street address
- [City, State, ZIP] – Your city, state, and ZIP code
- [Email Address] – Your preferred email address
- [Phone Number] – Your contact phone number
- [Date] – The date you are submitting the letter

**For the recipient section:**

- [Special Education Director or School Principal] – The name of the person you are addressing at the school
- [School District Name] – The name of your child's school district
- [District Address] – The mailing address of the school district
- [City, State, ZIP] – The city, state, and ZIP code of the school district

**The body of the letter**

**Subject:** Request for 1:1 Support Services Funding for [Student's Name]

Dear [Recipient's Name],

I am writing to formally request that [School District Name] provide funding for 1:1 support service for my child, [Student's Full Name], [DOB], who currently has an active IEP that includes 1:1 assistance during the school year. Due to the current level of function and my child's needs to provide a safe and Least Restrictive Environment (LRE). For my child this is essential to ensure a safe and guarantee LRE is being praised.

As [Student's Name] will be attending LIMITLESS PEDIATRIC SOLUTIONS, (Address), (Phone), [limitlesspedsoffice@gmail.com](mailto:limitlesspedsoffice@gmail.com) Summer Camp \_\_\_\_ Aftercare \_\_\_\_ Program, we are seeking continued 1:1 support to ensure consistency in services and to prevent regression of critical skills, as outlined in their IEP. These services are essential for [Student's Name] to access and benefit from the program in accordance with the Free Appropriate Public Education (FAPE) requirements under IDEA.

We are aware that South Carolina recognizes the need for Extended School Year (ESY) services and related support when necessary. Given [Student's Name]'s documented needs, we believe that the district is obligated to either provide or fund these services through a waiver or reimbursement process.

Please let us know the next steps to initiate this request, including any required documentation or waiver forms. We are happy to meet with the IEP team to discuss this further.

Thank you for your attention to this matter and for your continued support of [Student's Name]'s educational needs.

Sincerely,  
[Your Name]



## ABA SERVICES

ELIGIBILITY & PROCESS FOR ABA SERVICES	ABA PROVIDERS
<ul style="list-style-type: none"> <li>- Have a diagnosis of autism spectrum disorder (ASD)</li> <li>- Exhibit behavioral challenges that interfere with learning, communication, or daily functioning</li> <li>- Need support with social skills, communication, self-regulation, or adaptive behaviors</li> <li>- Are at risk of regression or have difficulty generalizing skills across settings (e.g., home, school, community)</li> <li>- If your child has an IEP and requires 1:1 support service, you may be eligible for funding through the school district or request services to an ABA provider.</li> <li>- Children may also qualify for ABA or related developmental services through South Carolina's Early Intervention (EI) Program if: They are under age 6 and show signs of developmental delays in one or more areas: Cognitive, Physical, Social/emotional, Communication (receptive and/or expressive), Adaptive developmental skills</li> <li>- They have a diagnosed condition or are at risk of significant developmental problems without intervention.</li> <li>- They have had a STAT screening (Screening Tool for Autism in Toddlers and Young Children) or other approved developmental screening that indicates concern. <b>Limitless Pediatric Solutions is Certified to perform STAT screenings</b></li> <li>- They are eligible for services through the South Carolina Department of Disabilities and Special Needs (DDSN) or the South Carolina School for the Deaf and the Blind (SCSDB).</li> </ul>	<p>Contact the providers listed below to learn more about their payment options and requirements. Visit the provider's website for more information, call or email the provider using the contact information listed below</p> <ol style="list-style-type: none"> <li>1. Full Spectrum ABA <ul style="list-style-type: none"> <li>- Website: <a href="https://www.fullspectrumaba.com/sclocations/">https://www.fullspectrumaba.com/sclocations/</a></li> </ul> </li> <li>2. Autism Inc. <ul style="list-style-type: none"> <li>- Address: 29 Plantation Park Dr, Bluffton, SC 29910</li> <li>- Phone: (843) 706-0831</li> <li>- Website: <a href="https://www.lafinc.org/">https://www.lafinc.org/</a></li> </ul> </li> <li>3. Behaviors A Go-Go, LLC <ul style="list-style-type: none"> <li>- Bluffton Location: Accepting clients for natural environment ABA services</li> <li>- Phone: (864) 757-9918</li> <li>- Website: <a href="https://www.behaviorsagogo.com/">https://www.behaviorsagogo.com/</a></li> </ul> </li> <li>4. Boost Behavioral <ul style="list-style-type: none"> <li>- ABA Therapist: Kelsey Freeze</li> <li>- Email: <a href="mailto:kelsey@boostbehavioral.com">kelsey@boostbehavioral.com</a></li> <li>- Phone: 912-655-9431</li> </ul> </li> <li>5. PBS (Positive Behavior Supports Corporation) <ul style="list-style-type: none"> <li>- Phone: (704) 440-5010 ext. 5005</li> <li>- Phone: (843) 983-8320 ext. 3244</li> </ul> </li> <li>6. Wright Directions Family Services <ul style="list-style-type: none"> <li>- Phone: 888-908-7339</li> </ul> </li> <li>7. Rays of Hope Behavioral Health <ul style="list-style-type: none"> <li>- Address: 7 Plantation Park Drive, Unit 4, Bluffton, SC 29910</li> <li>- Phone: (843) 706-2296</li> <li>- Website: <a href="https://mirasolhealth.org/services/rays-of-hope-behavioral-health/">https://mirasolhealth.org/services/rays-of-hope-behavioral-health/</a></li> </ul> </li> </ol>

## MEDICAID PAYMENT OPTIONS

If your child is eligible for Medicaid, you may be able to use it to cover the cost of ABA services. Medicaid (Healthy Connections) covers ABA services for children ages 0-21 if they meet medical necessity criteria. Private Insurance: Under Ryan's Law, some employer-sponsored plans must cover ABA therapy for children diagnosed before age 8 and up to age 16. South Carolina Medicaid (Healthy Connections) also provides non-emergency medical transportation (NEMT) for covered services like ABA therapy. This service must be scheduled in advance and is managed through ModivCare.



## Childcare Financial Assistance Resources

At Limitless Pediatric Solutions, we know that navigating childcare costs and funding options can be challenging. While we do not assist with applications, we've created this resource – to provide families with clear, helpful information about local programs and organizations that may offer financial assistance.

<p><b>SC Child Care Scholarship Program (Formerly SC Voucher)</b></p> <p>The SC Child Care Scholarship Program helps families afford childcare so parents can work, attend school, or receive job training.</p> <p>Eligibility:</p> <ul style="list-style-type: none"> <li>- Children ages 0-12 (up to 18 with special needs)</li> <li>- Parents must work at least 15 hours/week or attend school/training</li> <li>- Household income must be at or below 85% of the state median income (e.g., up to \$83,446 for a family of four)</li> </ul> <p>More info: SC DSS Child Care Scholarship Program</p>	<p><b>First Steps 4K Program</b></p> <ul style="list-style-type: none"> <li>• What it is: A state-funded program offering free 4K education to eligible children.</li> <li>• Eligibility: Must be 4 years old by September 1 and meet income or risk factor criteria.</li> <li>• How to apply: Complete the online registration at SC First Steps. <a href="https://www.scfirststeps.org/what-we-do/programs/first-steps-4k/apply">https://www.scfirststeps.org/what-we-do/programs/first-steps-4k/apply</a></li> </ul>
<p><b>Other Local Childcare Assistance Resources</b></p> <p>1. Bluffton Self Help</p> <ul style="list-style-type: none"> <li>- Offers emergency financial assistance, including for childcare.</li> <li>- 39 Sheridan Park Circle, Bluffton, SC</li> <li>- (843) 757-8000</li> <li>- blufftonselfhelp.org</li> </ul> <p>2. Lowcountry Community Action Agency (LCAA)</p> <ul style="list-style-type: none"> <li>- Provides Head Start, Early Head Start, and other family support services.</li> <li>- 1605 Jefferies Hwy, Walterboro, SC</li> <li>- (843) 549-5576</li> <li>- lowcountrycaa.org</li> </ul> <p>3. Deep Well Project (Hilton Head/Bluffton)</p> <ul style="list-style-type: none"> <li>- Offers daycare fee assistance, school supplies, and emergency aid.</li> <li>- (843) 785-2849</li> <li>- deepwellproject.org</li> </ul>	<p><b>Churches &amp; Faith-Based Organizations Offering Support</b></p> <p>1.-Lord of Life Lutheran Church - <del>PlayCare</del> (Bluffton)</p> <ul style="list-style-type: none"> <li>- Affordable part-time childcare for ages 1-5.</li> <li>- 351 Buckwalter Pkwy, Bluffton, SC</li> <li>- (843) 368-7205</li> <li>- lordoflife-bluffton.org</li> </ul> <p>2.-Creative Church (Hardeeville)</p> <ul style="list-style-type: none"> <li>- Offers childcare during services and community outreach (food/clothing).</li> <li>- 1293 Plantation Dr, Hardeeville, SC</li> <li>- (843) 784-5424</li> <li>- creativechurchsc.com</li> </ul> <p>3.-Greater Pentecostal Temple (Hardeeville)</p> <ul style="list-style-type: none"> <li>- Offers food, clothing, GED classes, and a summer literacy camp for kids.</li> <li>- 5905 S. Okatie Hwy, Hardeeville, SC</li> <li>- (843) 784-6988</li> </ul>
<p><b>Additional Community Resources</b></p> <p>1.-Agape Family Life Center (Hardeeville)</p> <ul style="list-style-type: none"> <li>- Offers youth programs, family support, and wellness services.</li> <li>- (843) 784-6008</li> <li>- agapeflc.org</li> </ul> <p>2.-Antioch Educational Center (Jasper County)</p> <ul style="list-style-type: none"> <li>- Provides education, job training, and health services for low-income families.</li> <li>- (843) 645-9400</li> </ul> <p>3.-Beaufort-Jasper YMCA of the Lowcountry</p> <ul style="list-style-type: none"> <li>- Offers after-school care, summer camps, and financial assistance.</li> <li>- Bluffton &amp; Beaufort locations</li> <li>- (843) 521-1504</li> <li>- ymcabeaufortcounty.com</li> </ul>	<p>4.-Bluffton Jasper Volunteers in Medicine</p> <ul style="list-style-type: none"> <li>- Free medical care for uninsured families, including children.</li> <li>- (843) 645-9090</li> </ul> <p>5.-Boys &amp; Girls Clubs of the Lowcountry</p> <ul style="list-style-type: none"> <li>- Affordable after-school and summer programs for children.</li> <li>- (843) 379-5430</li> <li>- bgclowcountry.org</li> </ul> <p>6.-Community Foundation of the Lowcountry</p> <ul style="list-style-type: none"> <li>- Connects families with local grants and nonprofit services.</li> <li>- (843) 681-9100</li> <li>- cf-lowcountry.org</li> </ul>