Welcome to the Limitless Family! ⭐

We are delighted that you have chosen to enroll with us. Our all inclusive programs are designed to provide a unique and exceptional educational experience for all of our young learners. Our program prides itself on promoting social and cultural diversity. We tailor our environment to each child's needs to ensure that everyone receives the support they need to thrive. We have a bilingual team of teachers and therapists in constant training who together are passionately dedicated to helping our young students progress.
At Limitless, we believe in unleashing every student's full potential and giving them the tools they need to excel in all areas of life.
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:_____

- ☐ Follow social media sites
  - ☐ Download Whats App
  - ☐ Instagram
  - ☐ Facebook
  - ☐ TikTok
- ☐ ID pictures of parents and authorized people to pick up
- ☐ Insurance Card
- ☐ Immunization Records (DHEC Form 4024)
- ☐ LIMITLESS CONTRACT
- ☐ REGISTRATION- DSS FORM 2900
- ☐ PARENT POLICIES REVIEWED (see Family Handbook)
- ☐ SIGN FAMILY HANDBOOK YEARLY
- ☐ GETTING TO KNOW YOU (CHILD) FORM
- ☐ RELEASE OF CHILD POLICY
- ☐ WAIVER FORM
- ☐ DISCIPLINE AND MALTREATMENT POLICY
- ☐ CHILD'S HEALTH/EMERGENCY CONTACTS FORM 0037
- ☐ PICTURE AND VIDEO CONSENT FORM
- ☐ COPIES OF CHILD'S IEP, 504, OR LATEST OT/PT/ST EVALUATION
- ☐ How to apply for ABC SC Vouchers
- ☐ ABC Connection form
- ☐ ABC letter of approval
- ☐ ABC letter with rate approved
- ☐ CACFP Form 16160
- ☐ CREDIT CARD AUTHORIZATION FORM
- ☐ CALENDAR

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

Limitless Pediatric Solutions

Janine Bickham **4 Oliver Ct suite 105** **Bluffton SC 29910** **(843)706-9367** **CC 043545** **Child Care Center**	**Tonya Allen-Jenkins** **21563 Whyte Hardee Blvd** **Hardeeville SC 29927** **(843)208-6121** **CC046375** **Child Care Center**

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

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Limitless Pediatric Solutions
Family Handbook

Contact information:

License # 25097
Director- Janine Bickham
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@limitlesspeds.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 :_____

Print Name:_____ Signature:_____ Date 5th year :_____

Print Name:_____ Signature:_____ Date 6th 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

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☐ Prefers to play alone/ withdrawn ☐ Shows Safety Awareness ☐ Impulsive/Restless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

Janine Bickham 4 Oliver Ct suite 105 Bluffton SC 29910 (843)706-9367 CC 043545 Child Care Center	Tonya Allen-Jenkins 21563 Whyte Hardee Blvd Hardeeville SC 29927 (843)208-6121 CC046375 Child Care Center

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_____

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_____
Reviewed by_____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 guidency.

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 :_____
Print Name:_____ Signature:_____ Date 5th year :_____
Print Name:_____ Signature:_____ Date 6th year :_____

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

Iauthorize 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, theirservices 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**_____

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_____
Reviewed by_____Date_____

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

- ☐ IEP (Individualized Education Plan)
- ☐ 504
- ☐ Latest OT/PT/ST

How to apply for ABC SC Vouchers

The South Carolina Child Care Scholarship Program, formerly known as The SC Voucher Program, has a new benefit portal. In order to apply, clients must visit: https://benefitsportal.dss.sc.gov/#/login and follow the link to apply for Child Care Scholarships. Clients will apply and upload all required documents through the benefits portal. They will also be able to check the status of their application anytime, 24/7!

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:
Child's Name (First and Last) **List only the child(ren) that have been approved for SC Voucher Program services.**	**Type of Care Needed** (Circle One)		**Requested Start Date** (Note: This date may not coincide with the approved transfer date.)
	Full-Time	Half-Time Both	Start Date:
	Full-Time	Half-Time Both	Start Date:
	Full-Time	Half-Time Both	Start Date:
	Full-Time	Half-Time Both	Start Date:
	Full-Time	Half-Time Both	Start Date:
	Full-Time	Half-Time Both	Start Date:
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.

DSS
SOUTH CAROLINA
DEPARTMENT of SOCIAL SERVICES

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

DSS FORM 3792 (APRIL 22) Edition of MAR 18 is obsolete.

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

DSS SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

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.

CHECK ALL THAT APPLY

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
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ 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 **FDPIR**?

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	Bi-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? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance Child Support Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement Social Security/SSI/ VA Benefits/Other	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

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 - ☐☐☐☐

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

DSS
SOUTH CAROLINA
DEPARTMENT of SOCIAL SERVICES

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

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, 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.

***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	Categorial Eligibility	Eligibility FREE	REDUCED	PAID	For Child Care Homes Only: Tier I_____ Tier II_____
	☐	☐	☐	☐		☐	☐	☐	☐	

Determining Official's Signature	Date	Confirming Official's Signature	Date

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. We require a 30 day withdrawal period to cancel this authorization.

CREDIT CARD INFORMATION
Card Type ____ MasterCard _____Visa _____Amex _____Discover _____Other
Cardholder Name: (as seen on the card): _____
Card Number: _____
Expiration Date: _____ 3 Digit Security Code: _____
Cardholder ZIP Code: _____

I, _____ authorize Limitless Pediatric Solutions to charge my credit card above for agreed upon services. I understand that my information will be saved on file for future transactions to my account. A 5% PROCESSING FEE IS ADDED.

_____ _____

Customer Signature **Date**

LIMITLESS PEDIATRIC SOLUTIONS | HARDEEVILLE CALENDAR 2024-2025

July 24

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August 24

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September 24

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October 24

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November 24

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December 24

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January 25

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 25

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March 25

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April 25

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May 25

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 25

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Close | Holiday | Vacation days

Early dismissal 12:30 pm

Regular school day

Report Cards | Parent-Teacher Conferences

2024

July 4th Independence Day
July 30th Last 4K Day 2023-2024
August 12th – 16th Summer transition
August 19th First 4K Day 2024-2025
September 2nd Labor Day
November 5th Election Day
November 11th Veteran's Day
November 25th-29th Thanksgiving Break
December 23rd-January 3rd Winter Break

2025

January 20th Martin Luther King Holiday
January 22nd School closure
March 31st School closure
April 18th – 25th Spring Break
May 22nd Graduation Ceremony
May 26th Memorial Day

LPS Professional development Days| 3:00 pm: July 26th | August 30th | September 27th | October 25th | November 22nd | December 20th
January 31st | February 28th | March 28th | April 11th | May 30th | June 27th

LIMITLESS PEDIATRIC SOLUTIONS | BLUFFTON CALENDAR 2024-2025

July 24

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

August 24

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September 24

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October 24

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November 24

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December 24

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January 25

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 25

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March 25

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April 25

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May 25

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 25

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Close | Holiday | Vacation days

Early dismissal 12:30 pm

Regular school day

Report Cards | Parent-Teacher Conferences

2024

July 4th Independence Day
July 30th Last 4K Day 2023-2024
August 19th First 4K Day 2024-2025
September 2nd Labor Day
November 5th Election Day
November 11th Veteran's Day
November 27th-29th Thanksgiving Break
December 23rd-January 7th Winter Break

2025

January 20th Martin Luther King Holiday
January 22nd School closure
February 14th – 19th School closure
March 17th School closure
April 14th – 18th Spring Break
May 21st Graduation Ceremony
May 26th Memorial Day
May 30th – June 3rd School closure

LPS Professional development Days|3:00 pm: July 26th | August 30th | September 27th | October 25th | November 22nd | December 20th
January 31st | February 28th | March 28th | April 11th | May 30th | June 27th