THE DIAMOND Child Development Center

STUDENT INFORMATION SHEET 2026/27

❑ ALLERGY/FOOD RESTRICTION ❑ NO PHOTO ❑ NON-AUTHORIZED PICKUP

STUDENT

Full Name: _____
First Middle Last Prefers to be Called

Main Home Address: _____
Street City State Zip Code

Birthdate: _____ Gender: _____ Ethnicity/Race: (Required for DSS Reporting) ❑ American Indian/Alaskan Native ❑ Asian/Pacific Islander ❑ Bi/Multi-Racial ❑ Black/African American ❑ Hispanic/Latino ❑ White/Caucasian ❑ _____

PARENT/GUARDIANS

_____ Relationship: _____
First Last

Cell Phone: _____ Work Phone: _____ Employer: _____

Email: _____

Drivers License #: _____ Lives with Student ❑ Yes ❑ No Emergency Contact ❑ Yes ❑ No

_____ Relationship: _____
First Last

Cell Phone: _____ Work Phone: _____ Employer: _____

Email: _____

Drivers License #: _____ Lives with Student ❑ Yes ❑ No Emergency Contact ❑ Yes ❑ No

EMERGENCY CONTACTS (Other than Parents/Guardians)

ADDITIONAL Authorized Pick Up and Non-Authorized Pick Up on Last Page

_____ Relationship: _____
First Last

Cell Phone: _____ Alt Phone: _____ Drivers License #: _____

Authorized Pickup ❑ Yes ❑ No

_____ Relationship: _____
First Last

Cell Phone: _____ Alt Phone: _____ Drivers License #: _____

Authorized Pickup ❑ Yes ❑ No

LIFE THREATING CONDITIONS (Please provide additional details on the next page)

Allergies: _____ EpiPen Provided ❑ Yes ❑ No

Medical Conditions: _____

PARENTAL PERMISSIONS

❑ Yes ❑ No I give permission for my child to participate in all routine daycare activities, including athletics, and be transported in daycare-approved transportation in the event of an emergency.

❑ Yes ❑ No I give permission for my child to be included in pictures and/or videos taken that may be displayed in our facility, used on our Website, posted to our YouTube Channel or on our Facebook Page.

_____ _____
Parent/Guardian Signature Date

STUDENT MEDICAL INFORMATION

Student's Doctor: _____ Phone#_____

Student's Dentist: _____ Phone#_____

CURRENT MEDICAL CONDITION

Please indicate all that apply to the student:

❑ Glasses/Contacts ❑ Hearing Loss ❑ Speech Defects
❑ Migraines ❑ Severe Headaches ❑ Epilepsy
❑ Bladder or Urinary Problems ❑ Heart Condition/Murmur ❑ Kidney Disorder

❑ ADD/ADHD (Taking Medication ❑ Yes ❑ No) Medication:_____

❑ Asthma (Medication/Inhaler ❑ Yes ❑ No) Medication:_____

❑ Diabetes (Medication/Insulin ❑ Yes ❑ No) Medication:_____

❑ Seizures - Describe_____ Medication:_____

❑ Life Threatening Allergies:_____ Medication:_____

❑ Other :_____ Medication:_____

_____

PRESCRIPTION MEDICATIONS

Only medications prescribed by a Doctor can be given by our Staff to your Child. All medicines must be in the original container with the Prescription and Dosage information. A completed Medication Consent Form must accompany each medication. If any other medications are needed, you must come to the Daycare and administer them to your child. Details for all Medical Policies and Procedures can be found the Student Handbook. By signing below, I acknowledge that I have read and understand the information above and agree to abide by the policy described and I have read and understand the Diamond Medication Procedures in the Student Handbook.

_____ _____
Parent/Guardian Signature Date

EMERGENCY MEDICAL AUTHORIZATION

In the event of an emergency, please **FIRST** contact: (Primary Contact) _____ at (Phone) _____. (If unable to reach, the individuals listed on child's Emergency Contact Information form will be contacted in the order provided.

If no Emergency Contact can be reached, I hereby authorize The Diamond Child Development Center to obtain emergency medical care for my child. I give permission for my child to be transported by ambulance or other emergency transportation to:(Preferer Medical Facility) _____, If necessary, my child may be transported to another appropriate medical facility as determined by emergency medical personnel.

I further authorize the attending physician, hospital, emergency medical personnel, or other licensed healthcare provider to examine, treat, and, if medically necessary, hospitalize my child. I also authorize The Diamond Child Development Center staff to administer emergency first aid, provide emergency care within the scope of their training, and administer medication when authorized or medically necessary during an emergency.

By signing below, I acknowledge that I have read and understand the information above and authorize the emergency medical treatment described herein.

_____ _____
Parent/Guardian Signature Date

TRANSPORTATION AUTHORIZATION

I give permission for my child, _____, to be transported
Student Name
by the Diamond Child Development Center in the event of an emergency and for the following:
Please check all that apply

- ❑ Emergency Situations
- ❑ Afterschool Transport, Northwest Elementary
- ❑ Afterschool Transport, Grassy Pond Elementary
- ❑ Daycare Activities/Field Trips (K4 & Up Only)

My signature below I acknowledge that I will be notified immediately in the event of any transportation needed due to an Emergency Situation and will be given advance notice any Daycare Activities requiring transportation.

Parent/Guardian Signature:_____ Date: _____

FINANCIAL RESPONSIBILITY

I hear by agree to make prompt payment in full of all Tuition, Fees and costs associated with the care provided by the Diamond Child Development Center.

Print Name: _____ Relationship to Student:_____

Signature: _____ Date:_____
Agreement to Pay – Financially Responsible Party

ACKNOWLEDGEMENT OF POLICIES

As regards my child, _____, my signature below signifies
Student Name
that I have read, understand, and agree with the expectations of The Diamond Child Development.
I understand that I will be held accountable for knowing and following ALL guidelines, policies, and expectations contained in this handbook. It further signifies the following:

- I have read and understand the and agree to follow the Discipline Policy of The Diamond Child Development.

- I have read and understand the procedure of evacuating the premises in case of an emergency have a clear understanding as to how the procedure would be carried out.

Parent/Guardian Signature:_____ Date: _____

STUDENT & FAMILY INSIGHT

This section is designed to help us understand your child's background, personality, and needs. By learning more about your home life, values, and your child's likes, dislikes, development and learning style, we can provide more personalized care and support. We ask that you fill out the following sections completely with as detailed and accurate information as possible. We apologize if these questions seem personal, however, this information will give us valuable insight into your child and how we can best care for them. The information you share helps us create a welcoming, inclusive, and nurturing environment where your child can thrive emotionally, socially, and developmentally. Thank you for partnering with us!

STUDENT INFORMATION

EATING, SLEEPING & ROUTINES

- Does your child have and difficulties or issues with food or eating? _____
- Describe your child's eating habits or preferences (picky eater, adventurous, favorite foods, etc.): _____

  _____
- Does your child have any food they intensely dislike? _____
- Do they have allergies or intolerance to any food? _____
- Does your child have and difficulties or issues with sleep? _____
- Typical nap/rest habits: _____
- Does your child nap during the day? ☐ Yes ☐
- Do they use a comfort item (e.g., pacifier, blanket, toy)? _____
- Does your child have separation issues at time of Drop Off? _____

PERSONALITY & PREFERENCES

- How would you describe your child's personality? _____
- What are your child's favorite activities, toys, or interests? _____
- What makes your child feel happy and confident? _____
- What are some things your child dislikes or avoids? _____
- Are there any fears, anxieties, or sensitivities we should be aware of (e.g., loud noises, animals)? _____

  _____

DEVELOPMENTAL & LEARNING INFORMATION

- Has your child been evaluated for or diagnosed with any of the following? (Check all that apply)

  ❑ Developmental delays ❑ Speech/language delays ❑ Physical disabilities ❑ Sensory Issues ❑ ADHD

  ❑ Behavioral challenges ❑ Autism spectrum ❑ Other: _____

  If yes, please describe the diagnosis and any therapies, supports, or accommodations your child currently receives:

  _____
- Are there any services your child receives outside of daycare? (e.g., OT, PT, speech therapy, counseling):_____

  _____
- Will you be arranging for your child to receive services (e.g., OT, PT, speech therapy, counseling) here at the Diamond, if so describe:_____
- Are there strategies, tools, or approaches that work well at home or in therapy that we can also use? _____

  _____

SOCIAL & EMOTIONAL DEVELOPMENT

- How does your child express emotions such as joy, frustration, or sadness? _____
- How does your child typically calm down when upset? _____
- Are there specific strategies you use to support your child when they are emotional? _____

FAMILY & HOME INFORMATION

FAMILY & HOME LIFE

- Primary Language(s) Spoken at Home: _____
- Other Language(s) Your Child Understands or Speaks: _____
- Who Lives in the Home with the Child? (e.g., parents/guardians, siblings, grandparents, etc.): _____
- Does your child have close relationships with extended family members? If yes, who and how often do they see them? _____
- Are there any recent changes in your family (e.g., move, new sibling, divorce, loss, etc.) that we should be aware of? _____

CULTURAL & RELIGIOUS BACKGROUND

- How would you describe your family's cultural background? _____
- Are there any important cultural traditions, customs, or holidays your family observes that we should know about? _____
- Does your family practice a particular religion or spiritual belief system? If yes, please describe any practices, dietary needs, or observances we should honor: _____

DIVERSITY & INCLUSION

- Is there anything else you'd like us to know about your family's culture, background, values, or traditions? _____
- Is there any diversity or inclusion-related information you feel would be helpful for us to know. (e.g., racial identity, language inclusion, cultural observances)? _____
- Are there any modifications or accommodations needed to ensure your child is included in all activities and routines? _____

GOALS & HOPES

- What are your hopes and goals for your child while they are with us at The Diamond? _____
- Is there anything else you'd like us to know so we can support your child's success and well-being? _____

AUTHORIZED PICKUP LIST

Please list anyone that is NOT ALREADY Listed that is authorized to pick up your child. Phone Number and Drivers License number must be provided.

Name: _____ Drivers License #_____

Cell Phone:_____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact ❑ Yes ❑ No

Name: _____ Drivers License #_____

Cell Phone:_____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact ❑ Yes ❑ No

Name: _____ Drivers License #_____

Cell Phone:_____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact ❑ Yes ❑ No

Name: _____ Drivers License #_____

Cell Phone:_____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact ❑ Yes ❑ No

Name: _____ Drivers License #_____

Cell Phone:_____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact ❑ Yes ❑ No

NON - AUTHORIZED PICKUP LIST

Please indicate anyone who is barred from picking up the student. If the person is one of the child's parents or legal guardians, The Diamond must have a copy of court papers on file in order to enforce.

Name: _____ Relationship: _____ Court Papers on File ❑ Yes ❑ No

Name: _____ Relationship: _____ Court Papers on File ❑ Yes ❑ No

Enrollment Date: _____ Withdrawal Date: _____ Door Code: _____

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: The Diamond Child Development Center County: Cherokee

Address: 115 D Macedonia Road Gaffney, SC 29341
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

Please Complete other side, sign and date

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

The Diamond Child Development Center
Name of Child Care Facility

Signature: _____ Date: _____
Parent or Guardian

Signature: _____ Date: _____
Director/Operator/Staff Designee

DSS
SOUTH CAROLINA
DEPARTMENT of SOCIAL SERVICES

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.

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	2xMonth	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 certifiying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2xMonth	Monthly	Public Assistance Child Support Alimony	How often? Weekly	Bi-Weekly	2xMonth	Monthly	Pensions/Retirement Social Security/SSI/ VA Benefits/Other	How often? Weekly	Bi-Weekly	2xMonth	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 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: **https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf**, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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: (833) 256-1665 or (202) 690-7442;
or
EMAIL: program.intake@usda.gov.

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

LETTER FOR NON-PRICING CHILD CARE INSTITUTIONS
Participating in the Child and Adult Care Food Program

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. The Diamond Child Development Center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Application for Free and Reduced-Price Meals in Child Care Food Program Forms (DSS Form 16160). This form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of Federal funding received by us. Please review the following questions and answers and the instructions for completing the attached DSS Form 16160.

1. **Do I need to fill out an Application for Free and Reduced-Price Meals form for each of my children in child care?** You may complete and submit one DSS Form 16160 for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to:** The Diamond Child Development Center, 115 D Macedonia Road, Gaffney, SC 29341 (864)487-7890
   (name of center, address, phone number)

2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), TANF also known as Family Independence (FI), or Food Distribution Program on Indian Reservations (FDPIR) can quality for free meals. Foster children and children enrolled in Head Start are also eligible for free meals. You must provide supporting documentation of a child's enrollment in the Head Start program.

3. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

4. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

   How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, FI or FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

5. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

6. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the DSS Form 16160, but are not required to include payments received for the foster child as income.

7. **What if some household members have no income to report?** Household members may not receive some types of income we ask you to report on the application, or may not receive income at all. Whenever this happens, please write a 0 in the field. However, if any income fields are left empty or blank, those will also be counted as zeroes. Please be careful when leaving income fields blank, as we will assume you meant to do so.

8. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

9. **What if there isn't enough space on the application for my family?** List any additional household members on a separate piece of paper, and attach it to your application. Contact (The Diamond Office) to receive a second application.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex (including gender identify and sexual orientation), age, disability or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

If you have other questions or need help, call The Diamond Office (864)487-7890.

Thank you for your cooperation.

Kim Bostic, Owner/Director
Institution Representative

INSTRUCTIONS FOR DSS FORM 16160

To apply for free and reduced-price meals, complete this application using the instructions below, sign your name and return the application to the center.

Step 1—List ALL Household Members who are infants, children, and students up to and including grade 12. Check if the child is enrolled in the Child Care facility, Foster Child, is in Head Start or is Homeless, Migrant or a Runaway. Check all that apply

Step 2—Households Getting SNAP, Participating in the Family Independence (FI) Program or Participating in the Food Distribution Program on Indian Reservations (FDPIR): List current SNAP, Family Independence or FDPIR case number. Complete steps 1 and 4. Do not complete step 3.

Step 3—If you did not provide a SNAP, FI or FDPIR case and you do not have an eligibility statement for Head Start or Even Start, complete this step and step 1.

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.

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 the 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" . If you enter "0" or leave any fields blank, you are certifiying (promising) that there is no income to report.. The applicant must also enter the Total Household Members, the Last Four Digits of Social Security Number (SSN) of the primary wage earner or other adult household member or check the box if the applicant does not have a SSN.

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

Step 4—Applicants must have the adult household member sign, print name, date and complete all other boxes in this step.

OPTIONAL—Ethnic/Racial Identity: Put a check (**0**) next to the ethnicity you identify with. Put a check (**0**) next to the race or races you identify with. We need the information to be sure everyone gets benefits on a fair basis. You do not have to answer these questions to get free or reduced price meals. USDA is an equal opportunity provider and employer.

Ethnicity:

1. Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

2. Not Hispanic or Latino.

Race:

1. American Indian or Alaskan Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

2. Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

3. Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

4. Native Hawaiian or Other Pacific Islander. A person having any origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

5. White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

THE DIAMOND Child Development Center

TUITION & FEES SCHEDULE

FULL TIME PROGRAM

Full & Half Time Tuition $160

Tuition Discounts

Family Discount $10 (Per Additional Child)

Holding Week 50% (2 Per Year – Attendance 1 Day or less)

Enrollment/Annual Registration & Insurance Fees (Nonrefundable) $140

Book Fees

2 Year Program	$ 75
3 Year Program	$100
K4 Program	$120

AFTERSCHOOL PROGRAM

Afterschool/Half Time Tuition $ 80

Afterschool /Full-Week Tuition $160

Enrollment/Annual Registration & Insurance Fees (Nonrefundable) $110

Discounts

Holding Week 50% (2 Per Year – Attendance 1 Day or less)

Full Day Charges (We are unable to provide Full Day care on E-Learning Days)

Full Day (In addition to Afterschool Tuition) $ 16

Full Day Week (Family Discount will apply) $160

SUMMER PROGRAM (Students Enrolled for Summer Only)

Tuition $160

Enrollment/Annual Registration & Insurance Fees (Nonrefundable) $110

Discounts

Family Discount $10 (Per Additional Child)

Holding Week 50% (1 Per Summer – Attendance 1 Day or less)

ADDITIONAL FEES

Late Payment Fee	$25
NSF Check Fee	$25
Late Pickup Fee	$10
Mat Fee	$10

Online Payment Fees

ACH/Bank Draft	1%
Credit/Debit Card	2.9% +.30¢ Transaction Fee
Online NSF Return Fee	$4

SC Child Care
EARLY CARE & EDUCATION

Child Care Scholarships

How to Qualify & Apply

The Child Care Scholarship Program, supported by the South Carolina Department of Social Services (DSS), makes child care more affordable for families so parents can work, attend school or training. The primary SC Working Families child care scholarship offering is known as the SC Working Families Child Care Scholarship.

To qualify for a SC Working Families Child Care Scholarship, parent(s) or guardian(s) must:

- have a child or children between birth and 12 years of age
- work at least 15 hours per week or attend school or a training program
- have a gross income at or below 85% of the state median income level; for a family of four this would be up to $83,446 annually

Other Ways to Qualify:

- Child care scholarships are available to support children ages 13 to 18 in certain circumstances: those who have disabilities, developmental delays or who are in foster care.

Income parameters for a SC Working Families Child Care Scholarship

Family Size	Gross Family Income Limit	
	Monthly	Annual
1	$0 - $3,616	$0 - $43,392
2	$0 - $4,729	$0 - $56,743
3	$0 - $5,841	$0 - $70,095
4	$0 - $6,954	$0 - $83,446
5	$0 - $8,066	$0 - $96,798
6	$0 - $9,179	$0 - $110,149
7	$0 - $9,388	$0 - $112,625

Ready to apply?

Child Care Scholarship eligibility requirement and online applications can be found at the DSS Child Care Website (https://scchildcare.org/families/child-care-scholarships/) and/or the DSS Benefits Portal (https://benefitsportal.dss.sc.gov/)

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