

# W4C'S / KIND CARE ENROLLMENT APPLICATION

<b>I. Child's Identification Information</b>			
Name		Nickname	
Sex	Birth Date	Parents Email	
<b>II. Family Information: Parents or Guardians</b>			
Name	Address & Phone	Place of Employment	Work Phone
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Foster Parent			
Names and ages of other children in the home:			
Name	Age	Name	Age
<b>III. Parental Sign in/out code</b>			
Name	Relationship	4 digit Code	
<b>IV. Special Needs</b>			
Child's Allergies & Dietary Restrictions			
Child's special needs			
Is your child receiving daily long-term medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Will W4C's or Kind Care need to administer medications during program hours? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, a Medication Authorization Form will need to be signed to give permission to administer medication. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Other (Specify):			
In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, age, disability, religion, sex, and familial status. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD)			

**PARENTAL EMERGENCY MEDICAL CONSENT**  
**This form must be presented upon admission for treatment.**

Child's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (phone number) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by below listed physician and/or dentist or in the event the designated practitioners are not available, then by another licensed physician or dentist. If it is necessary to transport my child to a hospital, the preferred hospital is \_\_\_\_\_ (preferred hospital).

**1. Parents/Guardians/Custodians with Whom the Child Resides:**

Name _____	Relationship to Child _____	
Address _____	Home Phone _____	Cell Phone _____
Employer _____	Email Address _____	
Work Phone _____	Work Hours _____	

Name _____	Relationship to Child _____	
Address _____	Home Phone _____	Cell Phone _____
Employer _____	Email Address _____	
Work Phone _____	Work Hours _____	

**2. Persons to Contact In Case of Emergency if Parents Are Unavailable, and are Authorized to Pick Up Child:**

Name _____	Relationship to Child _____	
Address _____	Home Phone _____	Cell Phone _____
Employer _____	Email Address _____	
Work Phone _____	Work Hours _____	

Name _____	Relationship to Child _____	
Address _____	Home Phone _____	Cell Phone _____
Employer _____	Email Address _____	
Work Phone _____	Work Hours _____	

**3. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?**

- Name \_\_\_\_\_
- Name \_\_\_\_\_

**4. Information:**

Physician name _____	Dentist name _____
Street address _____	Street address _____
City, State _____	City, State _____
Phone # _____	Phone # _____

Date of Last Tetanus \_\_\_\_\_ Known Allergies \_\_\_\_\_

Present Medication \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Holder's I.D. \_\_\_\_\_

This consent will be in effect for one year beginning (date) \_\_\_\_\_.

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

# W4C's / K.I.N.D. Care Admission Agreement

## ATTENDANCE:

- I will notify the center staff as early as possible when my child will not be participating or arriving late.
- I or an adult I designate, will bring and pick up my child from the center at scheduled times. All legal parent/guardians will be allowed to pick up their child/ren unless there is a legal document on file at the center stating otherwise.
- I will not permit my child to attend the center if he/she is sick or not able to physically participate in the daily activities.
- If my child becomes sick while at the center, I will arrange transportation for him/her to return home. If a medical emergency arises, the center staff will first attempt to contact me. If I cannot be reached or my established emergency contacts cannot be reached, the staff will contact my child's doctor. If necessary an ambulance or emergency vehicle may take my child to the hospital.

## FEES:

### Registration Fees: (non-refundable) (waived for DHS and Head Start families)

- W4C's - one-time \$60 per child
- KIND Care each School Year: New and Drop-In families - \$50 Full-time Existing families - \$30 (late registration fees may apply \$75, published deadline is determined each year)
- 
- KIND Care each Summer: New and Drop-in families - \$50 Full-time Existing families (priority reg.) \$30 (late registration fees may apply \$75, published deadline is determined each year)

### Activity Fee: to cover summer fieldtrips.

- KIND Care Summer Families including DHS Families \$65
- Payments of fees are due in advance on Monday's. If fees are not paid by 10:00 A.M. on Monday, a late charge of \$25 will be assessed to my account.
- If my account balance becomes two weeks delinquent, my child/ren must be withdrawn from the center until the entire balance is paid in full.
- Payment is due even if my child is absent during their reserved time slot.
- I will give a two week written notice of withdraw from the program. I will be responsible for regular payments during the two week period. If I do not give a two week notice, I agree to pay the two weeks tuition. Two week notices must begin on a Monday as we bill weekly M-F.
- Contract changes (K.I.N.D. Care only) - I may change my contract at any time with a two week written notice. I will be responsible for regular payments during the two week period. A \$25 fee will apply for **each** contract change.
- The 1 week's tuition is due (W4C's only), when my child's spot is guaranteed and reserved. This will be applied toward the last week of attendance. (non-refundable)

## OTHER PARENT RESPONSIBILITIES:

- I agree to ask questions and share concerns with the child care staff.
- I will dress my child properly for outside in play in current weather conditions.
- I will update the center staff of any changes to my child's file information as soon as I am aware of those changes.
- I give my permission for \_\_\_\_\_ (child's name) to participate fully in the W4C's / K.I.N.D Care programs.

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

\_\_\_\_\_  
Director Signature / Date

Over →

Please mark the boxes below that apply to you:

- I would like a receipt each time I make a payment.
- I would like a statement for the month at the beginning of each month.
- I would like a statement for the month at the end of each month.
- I would like a receipt only if I pay with cash.
- I will request a receipt or statement, only when I need one.
- I do not need either a receipt or a statement.
- I will need a statement of all charges and payments at the end of the year for my taxes.

**School Year K.I.N.D. CARE Program Fees (Kindergarten - 6<sup>th</sup> grade)**

\_\_\_\_\_ **AM only**      \$40/week  
Early Out - add \$17/day  
Late Start - add \$8/day  
No School Day - add \$22/day  
My child will attend (circle all that apply) Monday      Tuesday      Wednesday      Thursday      Friday  
My child will arrive approximately \_\_\_\_\_ A.M.

\_\_\_\_\_ **PM only**      \$60/week  
Early Out - add \$8/day  
Late Start - add \$17/day  
No School Day - add \$22/day  
My child will attend (circle all that apply) Monday      Tuesday      Wednesday      Thursday      Friday  
My child will depart approximately \_\_\_\_\_ P.M.

\_\_\_\_\_ **AM & PM**      \$85/week  
Early Out or Late Start - add \$6/day  
No School Day - add \$15/day  
My child will attend (circle all that apply) Monday      Tuesday      Wednesday      Thursday      Friday  
My child will arrive approximately \_\_\_\_\_ A.M. Depart approximately \_\_\_\_\_ P.M.

\_\_\_\_\_ **Drop-In:**  
Drop-In AM & PM - \$36/day  
Drop-In AM or PM - \$18/day  
Early Out or Late Start - add \$8/day  
No School Day - \$40/day  
My child will attend (circle all that apply) Monday      Tuesday      Wednesday      Thursday      Friday  
My child will arrive approximately \_\_\_\_\_ A.M. Depart approximately \_\_\_\_\_ P.M.

**NOTE:** Parents will have the option to sign their child up for all day care, on scheduled no school days. There will be a sign-up sheet located near the sign in/out computer. You must mark whether or not your child will be attending on these days. There will be a deadline to sign up that will be noted on the sign-up sheet; typically one week before the no school day. Using a scheduled no school day will have an extra fee in addition to the normal weekly tuition (see above).

If you sign up after the deadline or you don't sign up and your child does attend on the no school day, you will be charged an additional \$10 fee. If you have signed up for a no school day and your child does not attend, you will still be charged for the day unless you give a full 2 business day notice. Example: a Friday no school day begins at 6am so cancellation needs to be given by 6 am on Wednesday. Crossing your child's name off the list is not enough, you must communicate with staff. An email is preferred as it would be dated and trackable.

Child's Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
Routinely expect my child for early releases \_\_\_\_yes \_\_\_\_no (we will call each time)

I agree to pay tuition of \_\_\_\_\_ in advance. I will pay this  
\_\_\_\_ Weekly \_\_\_\_ Bi-Weekly \_\_\_\_ Monthly (five week months there will be an additional week of fees added)

\_\_\_\_\_  
**Parent Signature**

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

All W4C's and K.I.N.D. Care families,

This is just a reminder that all payments are due by Monday by 10 AM. Payments are due in advance.

**For example:**

- If you pay weekly, the payment is due by Monday 10 Am of the current week.
- If you pay bi-weekly, payment is due by Monday 10 Am of the 1st week, not the second.
- If you pay monthly, payment is due by Monday 10 AM of the first week of the month.

The payment box is checked at 10 AM or after each Monday. If your payment is there, you will not be charged a late fee.

Late fees will be assessed each time there is a late payment. If your payment is short for some reason, I may give you a reminder in your mailbox, but if the payment is short a second time, a late fee will be assessed at that time. If you don't pay the late fee at your next scheduled payment, you may be given a reminder, but if it remains unpaid at the next payment due date, you will be assessed another late fee and they will continue to accrue until paid in full.

You are able to check the balance of your account when you sign your child in or out. When you come to the screen where it says "Welcome" or "Goodbye", you can click on the "Ledger Card" box to see your account charges and credits. I know these can be confusing so if you have any questions, please let myself or Sandy know. If we aren't here when you are, send an email or call.

If you are having problems paying your tuition, please speak with Sandy or Barb. We are willing to try and work with you and your specific situation when you communicate with us.

Barb Blatter  
Office Administrator

# Annual Health Status –Parent Statement

(Kind Care Only Health statement to be completed by parent or guardian)

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Child's full name \_\_\_\_\_

Date of birth \_\_\_\_\_

1. Significant illness and or surgeries my child has had (give age at time)

\_\_\_\_\_

2. Is this child subject to any conditions which limit classroom activities or physical education?

\_\_\_\_\_

3. Is this child subject to any condition which may result in an emergency situation?

\_\_\_\_\_

Please ✓ in the box if the statement applies to your child

Plays with friends well – My child

- Plays well in groups with other children
- Will play only with one or two other children
- Prefers to play alone
- Fights with other children
- I am concerned about my child's play activity with other children

Body Health – My child has problems with

- |  |
|--|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Skin, hair, fingernails or toenails</li><li><input type="checkbox"/> Stomach aches or upset stomach</li><li><input type="checkbox"/> Eyes/vision, glasses or contact lenses</li><li><input type="checkbox"/> Using toilet, night time wetting</li><li><input type="checkbox"/> Ears/hearing, hearing aids or tubes in ears</li><li><input type="checkbox"/> Constipation, diarrhea</li><li><input type="checkbox"/> Nose problems, nosebleeds, breaths through mouth</li><li><input type="checkbox"/> Bones, muscles, pain moving</li></ul> |
|--|

- |   |
|---|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Mobility, uses assistive equipment</li><li><input type="checkbox"/> Mouth, teeth, gums, tongue, sores in mouth</li><li><input type="checkbox"/> Heart or heart murmur</li><li><input type="checkbox"/> Breathing, asthma, or on lips, cough</li><li><input type="checkbox"/> Frequent sore throats or tonsillitis</li><li><input type="checkbox"/> Nervous system, headaches, seizures or nervous habits like twitches</li><li><input type="checkbox"/> Female monthly periods</li></ul> |
|---|

Medication – My child takes medication

List medications taken at home, school or in child care. List the name, time taken and reason medication is prescribed.

Allergy – My child has the following allergies (food, medication, latex, inhalants, insects, animals etc)

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

# Iowa Department of Public Health Certificate of Immunization

Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis <i>DTap/DTP/D/T/</i> <i>Td/Tdap</i>		
Polio <i>IPV/OPV</i>		
Measles, Mumps, Rubella <i>MMR</i>		
Haemophilus influenzae type b <i>Hib</i>		
Hepatitis B		
Varicella Chicken Pox If applicant has a history of natural disease write "Immune to Varicella"		
Pneumococcal <i>PCV/PPV</i>		

Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal <i>MCV4/MPSV4</i>		
Hepatitis A		
Rotavirus		
Human Papilloma Virus <i>HPV</i>		
Other		

**Licensed Child Care Requirements**

<p><b>4 through 5 months</b> 1 dose Diphtheria/Tetanus/Pertussis 1 dose Polio 1 dose Hib 1 dose Pneumococcal</p> <p><b>6 through 11 months</b> 2 doses Diphtheria/Tetanus/Pertussis 2 doses Polio 2 doses Hib 2 doses Pneumococcal</p> <p><b>12 through 18 months</b> 3 doses Diphtheria/Tetanus/Pertussis 2 doses Polio 2 doses Hib or 1 dose received at ≥ 15 months of age 3 doses Pneumococcal if received 1 or 2 doses &lt; 12 months of age or has not received this vaccine before.</p> <p><b>4 years of age and older</b> 5 doses Diphtheria/Tetanus/Pertussis with at least 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000. 2 doses Polio with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000. 2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age, the second dose shall have been received ≥ 28 days after the first dose. 2 doses Hepatitis B if born on or after July 1, 1994. 2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but before September 15, 2003, unless the applicant has a reliable history of natural disease.</p>	<p><b>19 through 23 months</b> 4 doses Diphtheria/Tetanus/Pertussis 3 doses Polio 3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 12 months of age 1 dose Measles/Rubella ≥ 12 months of age, or a reliable history of natural disease. 4 doses Pneumococcal; or 3 doses if received 1 or 2 doses &lt; 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.</p> <p><b>24 months and older</b> Same requirements as the 19-23 months except 4 doses Pneumococcal if received 3 doses &lt; 12 months of age; or 3 doses if received 2 doses &lt; 12 months of age; or 2 doses if received 1 dose &lt; 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.</p> <p style="text-align: center;"><b>Elementary/Secondary School Requirements</b></p>
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# Over-The-Counter Medications Release

Name of child \_\_\_\_\_

I give my permission for appointed staff of W4C's / K.I.N.D. Care to apply or administer: (check all that apply)

\_\_\_\_\_ Apply sunscreen I have provided UVB and UVA protection of SPF 45-50 or higher (on children 6 months or older), to exposed skin as needed when there is sun exposure. NOTE: It is mandatory for children to have sunscreen on before they go outside.

\_\_\_\_\_ Apply lotion or Vaseline W4C's / K.I.N.D. Care has provided to my child's dry or itchy skin as needed.

\_\_\_\_\_ Apply cream I have provided to my child's dry or irritated skin as needed for itching or wounds and diaper rash. NOTE: Certain creams such as hydrocortisone, require a doctor's order.

\_\_\_\_\_ Administer Acetaminophen W4C's / K.I.N.D. Care has provided for fever or pain, under my direction, according to instructions provided by manufacturer. NOTE: For children under 2 years old, a doctor's order is required.

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Any medicine administered to the child will be recorded and kept on file. A copy of the record will also be given to the parent/guardian.

\_\_\_\_\_  
Signature of parent /guardian

\_\_\_\_\_  
Date (valid for 1 year)

(revised 2/20/17)

# PERMISSION STATEMENTS

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## Liability

I \_\_\_\_\_ parent/guardian of \_\_\_\_\_ will not hold W4C's / KIND Care in Williamsburg, IA liable for any injury or accident related to water activities held in conjunction with the daycare. This includes, but is not limited to, trips to the public or private pools, or for any activities held at the daycare center.

## Records Release Authorization

I hereby authorize and request (name of school) \_\_\_\_\_ to release to W4C's / K.I.N.D. CARE, a copy of the most recent immunization certificate and physical examination record of (name of child) \_\_\_\_\_ present in their school file.

## Transportation Authorization

In the event of an emergency evacuation or evacuation drills, I allow permission for my child to be transported to an alternate site (Williamsburg Recreation Center) via Williamsburg Community School bus or Iowa County Transportation. If we are evacuated to somewhere other than the Rec Center, parents will be notified.

## Picture Release

I Do, I Do Not (circle one) give permission to have my child appear in any media coverage approved by W4C's / K.I.N.D. CARE.

## Facebook

I Do, I Do Not (circle one) give my permission for my child's photo or video to be posted to their classroom's PRIVATE Facebook page. Classroom Facebook pages privacy settings are set to SECRET and are only shared with other classroom parents and W4C's administrative staff.

## Field Trips

I Do, I Do Not (circle one) give permission to have my child participate in center sponsored field trips, swimming, and off site activities.

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Signature of Parent/Guardian/Custodian

Date

## Pick-Up Authorization Form

My child, \_\_\_\_\_ (child's name) may leave W4C's / K.I.N.D Care into the following persons care:

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### Authorization for Child Pick Up

*"Do not release a child to anyone for whom you do not have a written authorization from the parent."*

-Department of Human Services (DHS), Rule Citation 441 IAC 109.9(2)

To assist us in keeping every child safe while in our care, please list upon registration, any person you wish to give authorization to pick up your child.

If, at any time, you wish for someone who is NOT listed to pick up your child, you must submit written authorization in person to the center **PRIOR** to when the child is to be picked up. (According to the DHS citation, email and phone calls are not valid methods of "written" authorization).

For safety reasons, please advise any person you have authorized, to be prepared to show our staff their ID before your child can be released to them.

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A **4 digit code** for each person authorized to log your child in/out is optional, however they must know a code to clock your child in or out. Please include your emergency contact person(s) as they may be picking up your child in case we cannot reach you in an emergency situation Update as necessary.

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1. Name _____	Phone _____	Relationship _____	Code _____
2. Name _____	Phone _____	Relationship _____	Code _____
3. Name _____	Phone _____	Relationship _____	Code _____
4. Name _____	Phone _____	Relationship _____	Code _____
5. Name _____	Phone _____	Relationship _____	Code _____
6. Name _____	Phone _____	Relationship _____	Code _____
7. Name _____	Phone _____	Relationship _____	Code _____
8. Name _____	Phone _____	Relationship _____	Code _____
9. Name _____	Phone _____	Relationship _____	Code _____
10. Name _____	Phone _____	Relationship _____	Code _____

Is there any **court order prohibiting** contact of your child with any person? \_\_ Yes \_\_ No, if 'Yes' **please provide a photocopy or order.**

Name of person(s) who **may not** pick up child

\_\_\_\_\_

\_\_\_\_\_

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

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Williamsburg Child Development Center  
802 Franklin St.  
Williamsburg, IA 52361  
319-668-9515 phone  
319-668-9513 fax  
[wburg4cs@gmail.com](mailto:wburg4cs@gmail.com)  
[kindcare@windstream.net](mailto:kindcare@windstream.net)

Dear Parents,

Please fill out and return the Iowa Eligibility Application regardless of whether or not you believe you may qualify for free or reduced price meals.

If you do not believe you qualify and do not wish to fill out income information, you do not need to provide that information. Please only fill out the names in parts 4 and 5 and sign and date the form.

This form assists us with paperwork we have to submit as part of our participation in the CACFP program. This information is only used for that purpose.

Note: We do not charge extra fees for meals; these forms help us determine what reimbursement we are eligible for under the CACFP program.

Thank you,

W4C's and K.I.N.D. Care

# Iowa Eligibility Application

FFY 19-20

**Complete one application per household. Fiscal Year 2019-2020**

**Part 1. Check all applicable boxes:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> school meals                      | <input type="checkbox"/> children in child care center | <input type="checkbox"/> children in child care home(HP) |
| <input type="checkbox"/> special milk (restrictions apply) | <input type="checkbox"/> Tier I home provider (HP)     | Provider name: _____                                     |
|  | <input type="checkbox"/> Head Start/Even Start         |  |

**Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school.**     Run away     Migrant     Homeless

**Part 3. FIP or Food Assistance Eligible:** Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

**Name of household member with Case Number** \_\_\_\_\_ **List Case Number**    -    -    -    -    -    -    -    -    -

**Part 4. Children enrolled: REQUIRED OF ALL APPLICANTS.**

List name(s) of all enrolled child(ren) in your household.			<b>Ethnicity:</b> H=Hispanic or Latino N=Not Hispanic or Latino		<b>Race:</b> A = Asian    B = Black or African American I = American Indian or Alaska Native W=White		<i>If ethnicity &amp; race are not completed, the form will be completed based on visual observation</i>	
Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL		Name of School/Head Start/Child Care Center/Home
						ETHNICITY	RACE	
1.			<input type="checkbox"/>					
2.			<input type="checkbox"/>					
3.			<input type="checkbox"/>					
4.			<input type="checkbox"/>					
5.			<input type="checkbox"/>					

**Part 5. Total Household Gross Income: DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3.** Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of <u>everyone</u> living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.					<b>Gross Income: Report income by how often the household member is paid.</b>				Other Monthly Payments or Income Received.		
Last Name	First Name	Age	Check if NO Income	Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income	
1.			<input type="checkbox"/>								
2.			<input type="checkbox"/>								
3.			<input type="checkbox"/>								
4.			<input type="checkbox"/>								
5.			<input type="checkbox"/>								

Last four digits of my Social Security Number: X XX - XX - \_\_\_\_ \_\_\_\_     I do not have a Social Security Number.  
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. For further information refer to the Privacy Act Statement in the parent letter.

**Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.**

I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form \_\_\_\_\_

Signature of Adult Completing Form _____	Printed Name of Adult Completing Form _____	Date Signed _____
Address of Adult Completing Form _____	Town _____	ZIP Code _____
	Work Phone _____	Home Phone _____
		Cell Phone _____

**Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.**

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12  
Household Income: \$ \_\_\_\_\_     Weekly     Every 2 Weeks     Twice Monthly     Monthly     Annually    Household Size \_\_\_\_\_

Application Approved: <input type="checkbox"/> Income <input type="checkbox"/> Foster Child (free)	<input type="checkbox"/> FIP/Food Assistance <input type="checkbox"/> Homeless/Migrant/Runaway (Schools only)	CACFP HP ONLY: <input type="checkbox"/> Tier 1 Area (Provider's own children)
<input type="checkbox"/> Head Start DOCUMENTATION REQUIRED		
Eligibility Determination: <input type="checkbox"/> Free Meals <input type="checkbox"/> Reduced Price Meals <input type="checkbox"/> Free Milk		<input type="checkbox"/> Tier 1 Income (All children)
Application Denied: <input type="checkbox"/> Incomplete <input type="checkbox"/> Over income limits		<input type="checkbox"/> Tier 1 Child (Tier 2 mixed)

Determining Official Signature _____	Effective Date _____
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**Self-Employment Income Worksheet: This worksheet will help you calculate the amount to report if you farm, are self employed, or have income from other sources.**

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA DOES NOT recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. **The least self employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 5 of the application.

**Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return - Form 1040 (including Schedule 1). Use the lines from the 1040, Schedule 1 identified below:**

Line 12 - Business income or (loss)	\$ _____
Line 13 - Capital gain or (loss)	\$ _____
Line 14 - Other gains or (losses)	\$ _____
Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc.	\$ _____
Line 18 - Farm income or (loss)	\$ _____
	Total \$ _____

**The least income possible is zero (a negative number cannot be reported)** Total ÷12\* = \_\_\_\_\_

\*Enter amount in the "Other Monthly Payments or Income Received" column in Part 5 on the front of the Iowa Eligibility Application.

**Income Eligibility Guidelines (IEGs) for Free and Reduced Price Meals**  
**Effective 7-1-2019 through 6-30-2020**  
 (For internal use only—do not distribute to families)

Household Size	Reduced Price Meals						Free Meals					
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly		Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly	
<b>1</b>	\$23,107	\$1,926	\$963	\$889	\$ 445		\$16,237	\$1,354	\$ 677	\$ 625	\$ 313	
<b>2</b>	\$31,284	\$2,607	\$1,304	\$1,204	\$ 602		\$21,983	\$1,832	\$ 916	\$ 846	\$ 423	
<b>3</b>	\$39,461	\$3,289	\$1,645	\$1,518	\$ 759		\$27,729	\$2,311	\$1,156	\$1,067	\$ 534	
<b>4</b>	\$47,638	\$3,970	\$1,985	\$1,833	\$ 917		\$33,475	\$2,790	\$1,395	\$1,288	\$ 644	
<b>5</b>	\$55,815	\$4,652	\$2,326	\$2,147	\$1,074		\$39,221	\$3,269	\$1,635	\$1,509	\$ 755	
<b>6</b>	\$63,992	\$5,333	\$2,667	\$2,462	\$1,231		\$44,967	\$3,748	\$1,874	\$1,730	\$ 865	
<b>7</b>	\$72,169	\$6,015	\$3,008	\$2,776	\$1,388		\$50,713	\$4,227	\$2,114	\$1,951	\$ 976	
<b>8</b>	\$80,346	\$6,696	\$3,348	\$3,091	\$1,546		\$56,459	\$4,705	\$2,353	\$2,172	\$1,086	
<b>For each additional family member add:</b>	+ \$8,177	+ \$682	+ \$341	+ \$315	+ \$158		+ \$5,746	+ \$479	+ \$240	+ \$221	+ \$111	



Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

May 2019

## Iowa Child and Adult Care Food Program Child Care Enrollment Form

Last Name, First Name	Birthdate	Times of Care		Regular Days of Care							Meals Served During Care					Ethnicity/Race*			
		Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E	Sn	Ethnicity	Race

\*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino

\*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander. This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, the center's Program representative is required to note race/ethnicity on the basis of visual observation.

**Infants only (0 to 12 months):**  I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

- I will provide breastmilk for my infant.  Yes  No Center formula may be used to supplement feedings if necessary:  Yes  No
- I would like to breastfeed on site, if this option is available<sup>1</sup>.  Yes  No If yes, time(s) \_\_\_\_\_
- I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): \_\_\_\_\_
- I accept the center's formula for my infant. Name of iron-fortified formula: \_\_\_\_\_
- I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: \_\_\_\_\_
- I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.
- I will provide solid foods for my infant<sup>2</sup>. The center may supplement with additional solid foods when my infant needs them:  Yes  No

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

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_ (Make any needed changes above, sign and date)

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_ (Make any needed changes above, sign and date)

<sup>1</sup>Ask your center if you can breastfeed on-site.

<sup>2</sup>The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

*This institution is an equal opportunity provider.*



**ALERT Iowa- Emergency Announcement Communication (See form below)**

The center has the ability to use the Iowa County Emergency Information System to contact families via (text message and or email) when the center has an emergency (lockdown, closings, evacuation etc.). Please fill out the requested information below so we can add your preferred contact information into the Emergency System.

Thank you,

---

Child Name: \_\_\_\_\_

**ALERT Iowa- Emergency Announcement Communication Family Preference**

**Please return to Sandy or Dani's mailbox ASAP**

Please mark your preference on receiving center-wide emergency notifications. It's okay to choose both email and text.

Email

---

Email address (print clearly)

Text Message:

---

Parent Phone Number (Father)

---

Parent Phone Number (Mother)

---

Parent Name (print clearly)

Date

(Revised 1/18/17)

# Williamsburg Child Development Center W4C's and K.I.N.D. Care

## Parent Handbook Acknowledgement

I, the undersigned, acknowledge that I have received a copy of the Parent Handbook for the Williamsburg Child Development Center (W4C's and K.I.N.D. Care). I recognize that it is my responsibility to read and understand the policies and procedures contained in the Parent Handbook. If I have any questions regarding the policies or procedures contained within the handbook, I will ask the Director for clarification.

In addition, I understand the contents of the handbook are subject to change. I acknowledge the Parent Handbook will be revised in accordance with the rules and regulations of State, Federal and accrediting entities for child care service providers or at the discretion of the Board of Directors for W4C's. I recognize that any such revisions will supersede, modify or eliminate the current contents of the Parent Handbook.

I acknowledge that it is my responsibility to stay informed of policy and procedure revisions to the Parent Handbook, which will be posted on the center website at [www.williamsburgchildcare.com](http://www.williamsburgchildcare.com). In the event that I do not have internet access, I understand that I can obtain a hard copy of the updated Parent Handbook upon request to the Director.

I am interested in being on the W4C's Board of Directors \_\_\_\_Yes \_\_\_\_No

\_\_\_\_\_  
Parent/Guardian Printed Name      Date      Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Printed Name      Date      Parent/Guardian Signature

If requested, hard copy of Parent Handbook Provided on \_\_\_\_\_

\_\_\_\_\_  
Center Director Signature

TO: New Families

RE: Front Door Entry Cards

You will receive 2 cards that will gain you entry to the Williamsburg Child Development Center when your child starts attending W4C's or KIND Care. You will not be charged for the cards unless you lose them or do not turn them in when your child is no longer attending. The cost is \$5.00 per card.

DO NOT write on the cards. You will be charged the \$5.00 if you write on the card because we will not be able to give that card out to someone else at a later date.

We understand that occasionally you may forget your card and need to be buzzed in. This is not a problem unless it happens on a regular basis as it does disrupt the classrooms and takes the teacher's attention away from the children.

If you have other people picking up your child, please make sure you include them on the Pick-Up Authorization sheet. If they are not listed as an authorized person, they will not be allowed to pick up your child. They will need to push the button and be buzzed in once they give their name and are verified to be on your pick up list. They may also be asked to show identification.

You may lend your card to an authorized person when they are coming to pick up your child, but you will still be responsible for the card if it is damaged or lost.

Thank you in advance for your cooperation. As always, if you have any questions, please don't hesitate to ask.

# **EARN FREE MONEY FOR THE CENTER WITHOUT ANY EFFORT!**

YOU MAY OR MAY NOT KNOW THAT WILLIAMSBURG COMMUNITY CHILD CARE CENTER - W4Cs PARTICIPATES IN FUNDRAISING OPPORTUNITIES WITH GOODSEARCH.COM. YOU CAN HELP WITHOUT DOING ANYTHING THAT YOU DON'T ALREADY DO. JUST START USING YAHOO! POWERED GOODSEARCH.COM AS YOUR SEARCH ENGINE AND GOODSEARCH DONATES MONEY TO YOUR FAVORITE CAUSE WHEN YOU SEARCH THE INTERNET, SHOP ONLINE OR DINE OUT AT LOCAL RESTAURANTS!

1. USE **GOODSEARCH.COM** TO SEARCH THE INTERNET AND THEY DONATE A PENNY PER (NEW) SEARCH TO YOUR CAUSE.
2. USE **GOODSHOP.COM** WHEN YOU SHOP ONLINE AND THEY DONATE A PERCENTAGE OF EVERY PURCHASE AND OFFER OVER 100,000 COUPONS TO HELP YOU SAVE MONEY TOO! YOU CAN SHOP AT MORE THAN 2,600 TOP ONLINE RETAILERS AND A PERCENTAGE OF YOUR PURCHASES WILL GO TO THE CHARITY OR SCHOOL OF YOUR CHOICE. YOU PAY THE SAME PRICE AS YOU NORMALLY WOULD, BUT A DONATION GOES TO YOUR CAUSE!
3. SIGN UP FOR THEIR GOODDINING PROGRAM AND THEY'LL DONATE A PERCENTAGE OF YOUR RESTAURANT BILL WHEN YOU EAT AT ANY ONE OF THOUSANDS OF PARTICIPATING RESTAURANTS. EAT AT OVER 10,000 PARTICIPATING RESTAURANTS NATIONWIDE AND YOU CAN EARN UP TO 6% OF EVERY DOLLAR SPENT ON THE MEAL AS A DONATION FOR YOUR CHARITY OR SCHOOL.

IT'S REALLY EASY; IT'S FREE AND TURNS SIMPLE EVERYDAY ACTIONS INTO A WAY TO MAKE THE WORLD A BETTER PLACE. PLEASE SIGN UP TODAY TO HELP SUPPORT WILLIAMSBURG COMMUNITY CHILD CARE CENTER - W4Cs.

**GO TO [WWW.GOODSEARCH.COM](http://WWW.GOODSEARCH.COM) TO GET STARTED.**

SEARCH THEIR 100,000 CHARITIES AND CHOOSE TO DONATE TO WILLIAMSBURG COMMUNITY CHILD CARE CENTER – W4Cs. THEN USE GOODSEARCH.COM FOR ALL OF YOUR INTERNET SEARCHING AND SHOPPING AND YOU WILL BE AUTOMATICALLY DONATING TO YOUR CHILD CARE CENTER!

THANK YOU FOR YOUR SUPPORT!



You can also read about Goodsearch in the NY Times, Oprah Magazine, CNN, ABC News and the Wall Street Journal.

## How Does CACFP work?

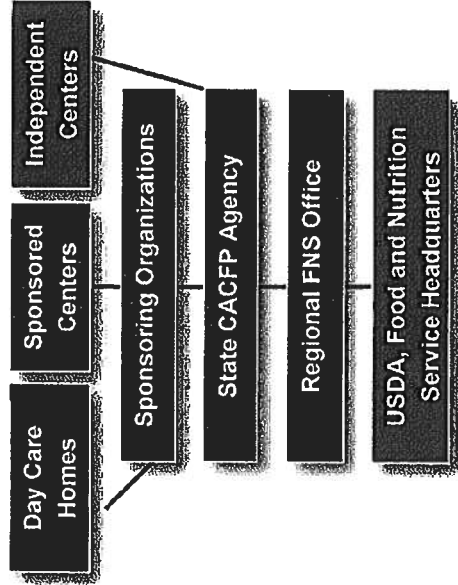
CACFP reimburses participating centers and day care homes for serving nutritious meals. It is administered at the Federal level by the Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA).

The **Iowa Department of Education** administers CACFP in Iowa. The State agency approves sponsoring organizations and independent centers to operate the Program at the local level. The State also monitors the Program and provides guidance and assistance to ensure requirements are met.

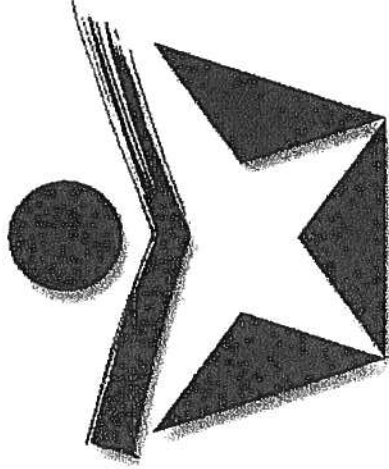
**Sponsoring organizations** play a critical role in supporting day care home providers and/or centers through training, technical assistance, and monitoring. Several types of organizations are approved by the State agency to serve as home or center sponsors, including community action agencies, nonprofit organizations, public agencies, and churches. Centers may operate independently, but all day care homes must come into the Program under a sponsoring organization.



## CACFP Partners



## Child and Adult Care Food Program (CACFP)



# Building Future

### Nondiscrimination Policies

#### USDA Nondiscrimination Statement:

USDA is an equal opportunity employer and provider

#### Iowa Nondiscrimination Statement:

It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14<sup>th</sup> St. Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: <https://icrc.iowa.gov/>.

Iowa Department of Education  
Bureau of Nutrition and Health Services  
Grimes State Office Building  
400 E. 14<sup>th</sup> St.  
Des Moines, IA 50319  
Phone: (515) 281-5356

## What is CACFP?

CACFP is the Child and Adult Care Food Program, a Federal program that provides reimbursement for serving healthy meals and snacks to children and adults receiving day care.

Each day more than 3.2 million children and almost 112,000 older adults participate in CACFP. Through CACFP, participants' nutritional needs are supported on a daily basis. The Program plays a vital role in improving the quality of day care and making it more affordable for many low-income families.

In addition to day care, CACFP helps make afterschool programs more appealing to at-risk children and youth. Afterschool centers that serve meals and snacks draw students into constructive activities that are safe, fun, and filled with learning opportunities.

Children who are homeless or from temporarily displaced families can also receive up to three meals each day through emergency shelters that operate the Program.

## Who is eligible for CACFP meals?

- Children age 12 and under,
- Migrant children age 15 and younger,
- Children and youths through age 18 in afterschool programs in low-income areas,
- Children and youths age 18 and under residing in emergency shelters, and
- Adults age 60 and older enrolled in an adult day care center, and functionally impaired adult participants in day care or emergency shelters.

## What kinds of meals are served?

CACFP facilities follow the meal patterns established by USDA.

- Breakfast requires of a serving of milk, fruit or vegetable, and grains or bread.
- Lunch and Supper require milk, grains or bread, meat or meat alternate, and two different servings of fruits and/or vegetables.
- Snacks require two different servings of the four components: milk, fruits or vegetables, grains or bread, or meat or meat alternate.

Infants follow a separate meal pattern.

## CACFP Facilities

Many different facilities operate CACFP, all sharing the common goal of serving nutritious meals and snacks to participants.

- **Child Care Centers**  
Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers serving meals to large numbers of low-income children.
- **Day Care Homes**  
Small groups of children receive nonresidential day care in DHS registered private homes.
- **"At-Risk" Afterschool Care Programs**  
Centers in low-income areas provide free meals and snacks to school-age children and youth.
- **Homeless Shelters**  
Emergency shelters provide temporary shelter and food services to homeless children.
- **Adult Day Care Centers**  
Public, private nonprofit, and some for-profit adult day care facilities provide structured, comprehensive services to functionally impaired nonresident adults.

