KIND Care Summer Program Contract 2020

Dates/Hours: The KIND Care summer program will be open Mon-Fri, 6:00 AM – 6:00 PM, Monday May 25 through Friday August 21. The center will be closed on Friday July 3rd[h].

Registration: (Check one) Registration fees are non-refundable. (Registration fees are waived for DHS families)

- New families and current drop-in status families:

  April 18 through May 1st - $50.00_____ After May 1st $75_____

- Current all year, full-time KIND Care families:

  April 1 through April 17 - $30 _____ After April 17 $50 After May 1st $75_____

Activity Fee: All Families including DHS - $65.00__X___ (Due at time of Registration)

Contracted weeks: (Check all that apply)

____Week 1, May 25 – May 29	____Week 2, June 1- June 5	____Week 3, June 8- June 12
____Week 4, June 15 - June 19	____Week 5, June 22 – June 26	____Week 6, June 29 – July 3
____Week 6, July 6 - July 10	____Week 7, July 13 - July 17	____Week 8, July 20 - July 24
____Week 9, July 27– July 31	____Week 10, Aug 3 - Aug 7	____Week 11, Aug 10 - Aug 14
____Week 12, Aug 17 - Aug 21		

Check one: 8 or more full weeks_____ 5-7 full weeks _____ 1-4 full weeks_____ *Fee - $150.00 per week* *Fee - $160.00 per week* *Fee - $165.00 per week*

Contract Changes: Changes may be made to this contract until May 1, 2020. After that date, you must give a paid, written two week notice to make changes.

Fees: You will be responsible for payment of all days and weeks contracted in this agreement regardless if your child does or does not attend. Weekly fees are due in advance on Mondays. A late charge of $25.00 will be assessed when fees are not paid by 10:00 AM on Monday 10 A.M.

- **How do you plan to pay?** (check one) Weekly_____ Bi-weekly_____ Monthly_____
  (Entire summer will be billed out at one time)

Prefer Part-Time Child Care for the Summer?

Drop-In Status: (Check if choosing this option) _____

- **You must register your child the same as above.**
- The fee for a drop-in day is $50 whether your child attends all or part of the day.
- You will need to provide a 24 hour advance notice if your child will attend.
- Payments for drop-in days will be due in advance as much as possible. When this is not possible, charges must be paid the following week.

About your Child:

Name_____

Child's Estimated arrival time_____ Estimated departure time_____

Child's T-shirt size: (Circle one) YS YM YL AS AM AL Child's grade (in the fall) _____

Is there anything you would like or need staff to know about your child?

Consent/Liability: *I give my consent for (child's name)* _____ *to participate fully in the W4Cs/KIND Care 2020 Summer Program, including fieldtrips, swimming and off-site visits.*

I will not hold W4Cs/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 other activities held at the daycare center.

_____ _____

Parent/Guardian Signature **Date**

W4C'S / KIND CARE ENROLLMENT APPLICATION

I. Child's Identification Information		
Name		Nickname
Sex	Birth Date	Parents Email

II. Family Information: Parents or Guardians			
Name	Address & Phone	Place of Employment	Work Phone

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Foster Parent

Names and ages of other children in the home:

Name	Age	Name	Age

III. Parental Sign in/out code			
Name	Relationship	4 digit Code	

IV. Special Needs
Child's Allergies & Dietary Restrictions
Child's special needs
Is your child receiving daily long-term medications? ☐ Yes ☐ No
Will W4C's or Kind Care need to administer medications during program hours? If yes, a Medication Authorization Form will need to be signed to give permission to administer medication. ☐ Yes ☐ 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 _____

(Revised 1/18/17)

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.

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 <u>each time</u> 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)

_____

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

- ☐ Skin, hair, fingernails or toenails
- ☐ Stomach aches or upset stomach
- ☐ Eyes/vision, glasses or contact lenses
- ☐ Using toilet, night time wetting
- ☐ Ears/hearing, hearing aids or tubes in ears
- ☐ Constipation, diarrhea
- ☐ Nose problems, nosebleeds, breaths through mouth
- ☐ Bones, muscles, pain moving
- ☐ Mobility, uses assistive equipment
- ☐ Mouth, teeth, gums, tongue, sores in mouth
- ☐ Heart or heart murmur
- ☐ Breathing, asthma, or on lips, cough
- ☐ Frequent sore throats or tonsillitis
- ☐ Nervous system, headaches, seizures or nervous habits like twitches
- ☐ Female monthly periods

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 *DTaP/DTP/DT/ Td/Tdap*			
Polio *IPV/OPV*			
Measles, Mumps, Rubella *MMR*			
***Haemophilus influenzae* type b** *Hib*			
Hepatitis B			
Varicella Chicken Pox If applicant has a history of natural disease write "Immune to Varicella"			
Pneumococcal *PCV/PPV*			

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

Licensed Child Care Requirements

4 through 5 months
- 1 dose Diphtheria/Tetanus/Pertussis
- 1 dose Polio
- 1 dose Hib
- 1 dose Pneumococcal

6 through 11 months
- 2 doses Diphtheria/Tetanus/Pertussis
- 2 doses Polio
- 2 doses Hib
- 2 doses Pneumococcal

12 through 18 months
- 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 < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

19 through 23 months
- 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 ≥ 15 months of age.
- 1 dose Measles/Rubella ≥ 12 months of age.
- 1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease.
- 4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

24 months and older

Same requirements as the 19-23 months except 4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses < 12 months of age; or 2 doses if received 1 dose < 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.

Elementary/Secondary School Requirements

4 years of age and older
- 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, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
- 4 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, 2003.
- 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.
- 3 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.

Rev. 12/2008

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.

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

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.

Signature of Parent/Guardian/Custodian Date

(Revised 3/30/18)

Pick-Up Authorization Form

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

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.

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.

---

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.**

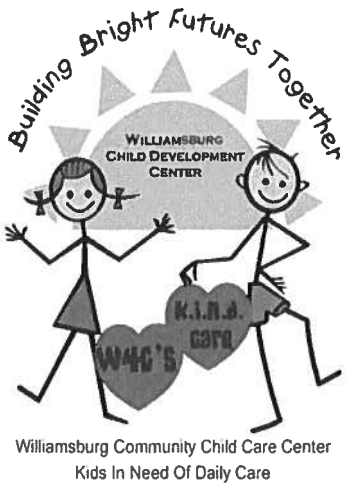
Name of person(s) who **may not** pick up child

_____

_____

Signature of Parent/Guardian _____ Date_____

(Revised 1/18/17)



Williamsburg Child Development Center
802 Franklin St.
Williamsburg, IA 52361
319-668-9515 phone
319-668-9513 fax
wburg4cs@gmail.com
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:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home(HP) Provider name:

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.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino **Race:** A = Asian B = Black or African American I = American Indian or Alaska Native W=White

If ethnicity & race are not completed, the form will be completed based on visual observation

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

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 everyone 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.

Last Name	First Name	Age	Check if NO Income	Gross Income: Report income by how often the household member is paid. Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: **X XX - X X -** ___ ___ ___ ___ ☐ 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: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance ☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

CACFP HP ONLY: ☐ Tier 1 Area (Provider's own children)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk

Application Denied: ☐ Incomplete ☐ Over income limits

CACFP HP ONLY: ☐ Tier 1 Income (All children) ☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature | **Effective Date**

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

CHILD & ADULT CARE FOOD PROGRAM

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

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Birthdate	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[1]. ☐ 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[2]. 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)

[1]Ask your center if you can breastfeed on-site.

[2]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. 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.

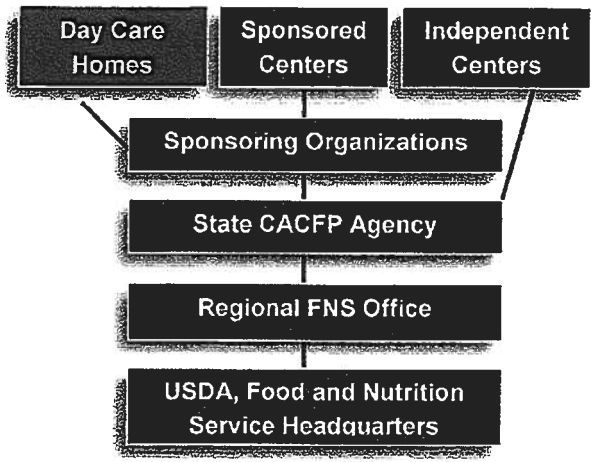
How Does CACFP work?

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



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. 14th St. Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: https://icrc.iowa.gov/.

Revised 6-22-2015

Child and Adult Care Food Program (CACFP)

Building FOR THE Future

Iowa Department of Education
Bureau of Nutrition and Health Services
Grimes State Office Building
400 E. 14th 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.

KIND Care – *Williamsburg Public Library*

This form MUST be returned BEFORE your child may check out library books when KIND Care visits the Williamsburg Public Library.

KIND Care Parents,

- **Please set up your family library account with the Williamsburg Public Library as soon as possible.**
- If your family does not have an account, your child may still enjoy visiting the library, but will not be allowed to check out any books. A family library account is needed in order for your child to check out books with KIND Care.
- **The library staff will NOT censor or restrict what materials the children check out.** However, KIND Care staff will do our best to be mindful of what materials are being checked out. If you find that your child has checked out something that you aren't ok with, please let us know.
- **KIND Care will allow the children to check out up to 2 books each week.** Please return the books the following week so they may be returned to the library during our next visit. (If your family decides to return the books checked out during our last visit, please let the KIND Care staff know that those books have been returned.)

My signature below implies that I have read and comply with the above points of interest and that I give permission for my child(ren) listed below to check out books at the Williamsburg Public Library with KIND Care:

Name on your Library Account _____

Child's Name _____ Child's Name _____

Child's Name _____ Child's Name _____

Parent Signature _____ Date _____

updated 4/2020