2021

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? No
If yes, a Medication Authorization Form will need to be signed to give permission to administer medication. Yes

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)

W4C'S AND KIND CARE CHILDREN

Favorite:

Snacks and Drinks:_____

Games:_____

Activities:_____

Talents: Instruments Dance Gymnastics Other:_____

Please give any other information you believe will be helpful to us in understanding your child:

_____

_____

_____ _____ _____ _____

Parent Signature Date Director Signature Date

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: W4C'S (infant – preschool) & Kind Care Programs (K-6th grade)

Registration Fees: (non-refundable) (waived for DHS and Head Start families) $75 if not paid by the published deadline, (determined each year)

- ☐ $60 - initial registration W4C's (infant–preschool) Annual Reregistration $30 every September
- ☐ $50 – ea. school year KIND Care (K-6th grade): New and Drop-In families
- ☐ $30 – ea. school year KIND Care (1st-6th grade): Fulltime existing families
- ☐ $50– ea. summer KIND Care (K-6th grade): New and Drop-In families (must have completed kindergarten)
- ☐ $30 – each summer KIND Care (K-6th grade): Full-time existing families

Activity Fee (Kind Care only K-6th Grade): to cover summer fieldtrips and enrichment activities.

- ☐ KIND Care Summer Families including DHS Families $65 (paid in April summer registration)

Other Fee Policy Information

- 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 in our Center. (non-refundable)
- Payments of fees are due in advance on Monday's by 10 Am, after 10 AM 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. Notices will begin on a Monday as we bill weekly M-F.

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 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.ND. Care programs.

_____

Parent/Guardian Signature / Date

W4C's Weekly Fees

(Fees are billed for the whole month and can be paid by the options below)

- **Yellow Ducks Room** (6 weeks to 12 months) - $190.00 per week
- **Red Birds Room** (12 months to 24 months) - $180.00 per week
- **Green Frogs Room** (2 to 3 years) - $180.00 per week
- **Blue Horses Room** (3 to 4 years) - $150.00 per week
- **Purple Cats Room** (4 to 5 years) - $150.00 per week

I agree to pay tuition of _____in advance by Mondays 10 AM. I will pay this:

_____Weekly _____Bi-weekly _____Monthly **(five week months there will be an additional week of fees added)**

_____ 50% Fulltime Staff Discount will apply

_____15% Part time Staff (min. 25 hours worked)

_____ _____

Parent Signature Date

PHYSICAL EXAM FORM

To be filled out by physician/health care provider:

Child's Name: _____ Age:_____ Date of physical:_____

Weight:	Height:	Blood Pressure:	Urinalysis:
Lead:	Hemoglobin	Vision Screen L R	Developmental Screen

Does the examination reveal any abnormality?	Normal	Abnormal	Not Examined	Describe any abnormal findings
General appearance, posture and gait				
Speech/Language Development				
Behavior during exam				
Skin				
Eyes: Extraocular movements				
Ears: Canal, Tympanic Membrane				
Noe, Mouth, Pharynx & Tonsils				
Teeth				
Heart				
Lungs				
Abdomen (includes hernias)				
Genitalia				
Extremities & Feet				
Neurological				
Other:				

Disability (diagnosed):	Treatment:

Summary of findings and recommendations: _____

_____

_____ _____

Signature of Physician or Health Care Provider
Stamp Here

Date Signed

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.

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 _____
2. Name _____ Phone _____ Relationship _____
3. Name _____ Phone _____ Relationship _____
4. Name _____ Phone _____ Relationship _____
5. Name _____ Phone _____ Relationship _____
6. Name _____ Phone _____ Relationship _____
7. Name _____ Phone _____ Relationship _____

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 7/29/21)

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, 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

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

Instructions for Completing Iowa Eligibility Application

Complete both sides of an application for each household.

All applicants should complete Part 1. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

FIP OR SNAP HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start, follow these instructions.

Part 3. List one FIP or SNAP **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

HOMELESS, MIGRANT OR RUNAWAY, follow these instructions.

Part 2. For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.

Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.

Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.

Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.

Part 5. Follow these instructions to report total household income from last month.

- **Name:** List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- **Age:** List the age of each household member.
- **Check If No Income:** Put a mark in the box if the household member **does not** have an income.
- **Gross Income last month and how it was received:** Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, or monthly). List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.
- **Other Monthly Payments or Income:** Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report**: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.
- **Social Security Number:** If the application is being made on the basis of income, 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. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.

Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 7/2021

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for SNAP or FIP, you may fill out an application at that time.

Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2021 to 6-30-2022

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$23,828	$1,986	$993	$917	$459
2	$32,227	$2,666	$1,343	$1,240	$620
3	$40,626	$3,386	$1,693	$1,563	$782
4	$49,025	$4,086	$2,043	$1,886	$ 943
5	$57,424	$4,786	$2,393	$2,209	$1,105
6	$65,823	$5,486	$2,743	$2,532	$1,266
7	$74,222	$6,186	$3,093	$2,855	$1,428
8	$82,621	$6,886	$3,443	$3,178	$1,589
For each additional family member add:	+ $8,399	+ $700	+ $350	+ $324	+ $162

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a SNAP number, or Family Investment Program number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

USDA Nondiscrimination Statement

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

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

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

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

Iowa Eligibility Application

FFY 21-22

Complete one application per household. Fiscal Year 2021-2022

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 SNAP Eligible: Enter the FIP or SNAP 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 SNAP 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. TO BE COMPLTED BY CENTER STAFF.
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/SNAP ☐ 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 meal benefits. 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 Tier 1 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 or household member in the operation of a farm or private business must be shown as household income in Part 5 of this Application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return – Form 1040 or 1040-SR including Schedule 1 (Additional Income and Adjustments to Income). Complete the identified lines from Form 1040 or Form 1040-SR and Schedule 1.

Capital gain or (loss): Form 1040 or 1040-SR, Line 7 $ _____

Business income or (loss): Schedule 1 Part 1, Line 3 $ _____

Other gains or (losses): Schedule 1 Part 1, Line 4 $ _____

Rental real estate, royalties, partnerships, S corporations, trusts, etc.:
Schedule 1 Part 1, Line 5 $ _____

Farm income or (loss): Schedule 1 Part 1, Line 6 $ _____

*Total = $ _____

*The least income possible is zero (a negative number cannot be reported).

*Enter amount in the "**All other income**" column in Part 5 on the front of this Application.

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.

RAVE- 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:_____

RAVE Iowa- Emergency Announcement Communication Family Preference

Please return to the office 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: **Cell Phone Carrier**_____

_____

Parent Phone Number (Father)

_____

Parent Phone Number (Mother)

Parent Name **(print clearly)** Date

(Revised 7/29/21)

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.

Dear Parents:

All payments are due on Mondays. Payments are due in advance. For example:

If you pay weekly, the payment is due on Monday of the current week.

If you pay bi-weekly, the payment is due on the first week, not the second.

If you pay monthly, the payment is due on Monday of the first week of the month.

If payment is not received by 10:00 a.m. on Monday a late fee of $25 may be assessed to your account.

Late fees will be assessed each time there is a late payment. If your payment is short for some reason, you may receive 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 a t 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 will receive a Statement of Charges once per month that will reflect all charges for the upcoming month. Statements will be printed the last Monday of the month which is one week before the next month's due date. Please note; the statement does not serve as a receipt since it will not reflect any payments that were made that last week of the month after the statement was printed. *Example: (July statement will be printed the last week (Monday) of June. You made a payment the last Tuesday of June. That payment will not be reflected since you paid it after the statement was printed. Your payments and charges for all of June will be reflected in the receipt you receive on or after the first billing Monday in July. Receipts are only provided upon request.*

Receipts will be printed within the first **billing week** of the month and reflect all previous month's transactions. *For example. June receipts will be printed the first billing week of July (first Monday of the month).*

Note: There will be 2 – 3 months during a year where there will be 5 billing Mondays rather than 4 billing Mondays per month. If you are a monthly payer please keep this in mind.

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

Thank you!

Office Administrator