

BRIGHT DAYS CHILD DEVELOPMENT CENTER
NEW ENROLLMENT CHECKLIST

STUDENT NAME _____

TODAY'S DATE _____

PROJECTED ENROLLMENT DATE _____

- Student Data Form
- Child Developmental History Form
- Medical History Form
- Permission for Daily Release Form
- Emergency Information Form/Emergency Authorization
- Publicity Release Form
- Fee Payment Contract
- Current Immunization Form
- Parent Handbook/Policy Guidelines Form

Funding Forms

- Food Form (CAFP)
- United Way
- State

BRIGHT DAYS CHILD DEVELOPMENT CENTER DATA FORM

Center Name _____ Today's Date _____ Enrollment Date _____

Child's Name _____ Nickname _____ Social Security # _____

 Last First Middle
Gender _____ Race _____ Birth date _____ Age _____ Classroom _____

Street Address _____ County _____

City _____ State _____ Zip _____ Home Phone () _____ - _____

Doctor's Name _____ Doctor's Phone Number () _____ - _____

Parent/Guardian #1 _____ SS# _____ Date of birth _____

Place of Employment _____ Position _____ Work Hours _____

Work Phone () _____ - _____ Cell Phone () _____ - _____ Home Phone () _____ - _____

e-mail address _____ Address of Employer _____

Marital Status ___ Single ___ Married ___ Divorced Number in Household _____

Income Bracket: ___ Below \$10,000 ___ \$10,000-14,000 ___ \$15,000-19,000
 ___ \$20,000-29,000 ___ Over \$30,000

Parent/Guardian #2 _____ SS# _____ Date of birth _____

Place of Employment _____ Position _____ Work Hours _____

Work Phone () _____ - _____ Cell Phone () _____ - _____ Home Phone () _____ - _____

e-mail address _____ Address of Employer _____

Emergency Contact #1 _____ () _____

 Name Phone Number Relationship Address

Emergency Contact #2 _____ () _____

 Name Phone Number Relationship Address

Days Attending: M TU W TH F Arrival Time _____ Departure time _____

Employee/Student Status: ___ Full Time ___ Part time ___ Seasonal

For Staff Use Only

Tuition _____ Date Received _____ Amount Cash ___ Check ___ Payment Type: ___ Full fee
___ Discount ___ United Way ___ State _____ State Worker's Name
_____ Income _____ UW Co-Pay per day _____ State Co-Pay per day
___ CCFP (Food Program) ___ Free ___ Reduced ___ Paid
Immunizations: Up-To-Date Certificate ___ Yes ___ No _____ Date Received _____ Exp. Date
Form Revised 2013

BRIGHT DAYS CHILD DEVELOPMENT CENTER
CHILD DEVELOPMENTAL HISTORY FORM

Child's Name _____ Date _____

Names and ages of siblings _____

Has your child been cared for by anyone other than parents? ___ Yes ___ No By
Whom? _____

Has your child previously attended a childcare center? ___ Yes ___ No ___ How Many? ___ For how
long?

Where did he or she attend _____

Does your child use the restroom independently? ___ Yes ___ No

Does your child need help dressing or undressing? ___ Yes ___ No

Does your child have any special fears? ___ Yes ___ No Of what? _____

Your child's favorite games _____

Favorite toys _____

Favorite books _____

Does your child dislike any particular food(s)? _____

What form of discipline is used? _____

At what age did your child:

Sleeping Habits:

Walk _____

Hours of sleep _____

Afternoon nap _____

Talk _____

Bedtime _____

Is your child toilet trained? ___ No ___ Yes At what age? _____

BRIGHT DAYS CHILD DEVELOPMENT CENTER
MEDICAL HISTORY FORM

Child's Name _____

Date _____

Does your child require special medical care, please explain? _____

Does your child have any allergies? ___ Yes ___ No What are they? _____

Does your child have a history of physical impairment? ___ Visual? ___ Speech problems? ___
Hearing?

Current prescribed medications _____

Medical Doctor _____ Doctor's Phone # _____

Physician Group Name & Address _____

Does your child have a medical card or insurance? Name of insurance carrier

Medical Card Number _____ Date Issued _____ Date of Expiration _____

Has your child even been to the dentist? ___ Yes ___ No Dentist Name _____

Dentist Group Name & Address _____

Age of child at visit dentist visit? _____ Date of last visit to dentist _____

Dentist Phone Number _____ Any specific dental problems? _____

Please circle any of the following illness your child has had:

Measles Mumps Diphtheria TB Heart Disease Chicken Pox

German Measles Rheumatic Fever Polio Diabetes Kidney Disease

Whooping Cough Epilepsy Other _____

Has your child ever been hospitalized? If yes, explain _____

Other information we should know about medical or dental concerns

Parent Signature _____

Date _____

Tell us about your child (socially, emotionally, special needs, etc.)

What are your hopes for your child as he or she participates in this program?

BRIGHT DAYS CHILD DEVELOPMENT CENTER
PERMISSION FOR DAILY RELEASE FORM

At the end of the day or during the day, my child _____
may be released only to the person(s) indicated below. **Any changes must be pre-approved through the office and provided by the parent/guardian. There will be no exceptions.**

	Name	Address	Phone	Relationship
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

At no time is my child, _____, to be released to the person(s) indicated below:

1. _____
2. _____
3. _____

Parent Signature

Date

BRIGHT DAYS CHILD DEVELOPMENT CENTER
FEE PAYMENT CONTRACT

General Enrollment Information

I, the parent/guardian of _____ understand that we are an enrollment based Center and agree to enroll my child based on the following attendance schedule:

Please circle all days child will be attending and indicate times below: M TU W TH
F

___ 1/2 day ___ Full day Time of arrival _____ Time of pickup _____

Self-Payment

I agree to pay the Center the fee of _____ per week, payable on Monday for the current week attending.

- I understand that if payment becomes two weeks behind my child my be disenrolled from the center.
- I understand that if I my child is absent due to sickness over five days a month, I am responsible to pay for any absence over five days. I also have to provide a statement detailing the sickness.
- I understand that if my child is absent for or vacation that I am still responsible for the fee.

Tuition Assistance Program

Number of family members: ___ adults ___ children Total (gross, not net) family income _____

___ I qualify for state funding.

___ I qualify for United Way funding.

- Note: I understand that if the state or United Way tuition assistance program refuses to provide payment for excessive absenteeism, I am responsible for any tuition balance that accrues.

Parent/Guardian

Date

BRIGHT DAYS CHILD DEVELOPMENT CENTER
PUBLICITY RELEASE FORM

Dear Parent/Guardian,

From time to time, there are different organizations, newspapers, TV stations, non-profit agencies, or internal needs to take photos, film the agency or activities and children, or to visit or publicize the program and/or activities of the center.

Name of child

I, the undersigned, hereby consent to the reproduction, publication, and other use of photographs or cinematic image and voice of my child by Children, Inc., in newspapers, TV stations, non-profit agencies or other organizations or businesses.

The undersigned grants the above-mentioned rights without compensation.

Parent/Guardian Signature

Date

KY Child and Adult Care Food Program Income Application

2014-2015 Child Care Centers

This form must have all sections complete in order for this center to qualify for reimbursement for meals served to your participants.

*For SNAP and K-TAP benefit information, please include the entire case number and skip section 3 then sign section 4.

1. CHILD INFORMATION (print)	2. PROGRAM BENEFITS				Kinship	Foster
Name of Child (Last, first)	Birthdate	SNAP#	K-TAP#			
1. _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
2. _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
3. _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
4. _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	
5. _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	

3. HOUSEHOLD MEMBERS AND MONTHLY INCOME:				
NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above	GROSS MONTHLY Income From Work (Before Deductions)	MONTHLY Income From Welfare Payments, Child Support, Alimony	MONTHLY Income From Pensions, Retirement, Social Security	Any Other MONTHLY Income Including Money Received from Kinship/Foster Child
Last, First				
1. _____	\$	\$	\$	\$
2. _____	\$	\$	\$	\$
3. _____	\$	\$	\$	\$
4. _____	\$	\$	\$	\$
5. _____	\$	\$	\$	\$

4. SIGNATURE AND SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X _____
Signature of Adult Household Member

X _____ No Social Security Number X _____
Last four digits Social Security Number* Date

Printed Name _____ Home Telephone No. _____ Work Telephone No. _____

Street/Apt.No. _____ City/State/Zip _____

5. Participant's ethnic and racial identities (optional) Mark one ethnic identity: _____ Hispanic or Latino _____ Not Hispanic or Latino
Mark one or more racial identities: _____ Asian _____ White _____ Black or African American _____ American Indian or Alaska Native
_____ Native Hawaiian or Other Pacific Islander

*See Policy Memo

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

<input type="checkbox"/> SNAP/K-TAP Household <input type="checkbox"/> Foster/Kinship Care <input type="checkbox"/> Income Household:	Application approved for: <input type="checkbox"/> Free Meals <input type="checkbox"/> Reduced Price Meals <input type="checkbox"/> Paid
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Total Household Monthly Income: _____
Household Size: _____

Signature of Determining Official Date W/D Date Re-enter Date

*7 CFR 226.23(e)(4)

Name of Site _____

CACFP ENROLLMENT FORM

1. Participant Information: (To be completed by Parent/Guardian)

Participant's Last Name	Participant's First Name	Date of Birth	Normal/Typical Hours of Care		Normal/Typical Days of Care (Circle all that apply)							Meals Normally Eaten (Circle all that apply)					
			To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
			To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
			To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
			To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
			To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
			To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN

*Parent/Guardian works multiple shifts and participants may be in care different days/hours ___yes ___no

Guide:

Normal hours of care: Please insert the usual arrival time and the usual departure time. Indicate a.m. or p.m.

Normal days of care: Please circle the days of the week the participant(s) are usually in attendance at the facility

(M=Monday;T=Tuesday;W=Wednesday;Th=Thursday;F=Friday;Sa=Saturday;Su=Sunday)

Meals Normally Eaten-Please circle the meals the participants usually eat at the facility.

(B=Breakfast;AM=AM Supplement;L=Lunch;PM=PM Supplement;S=Supper;LN=Late Night Supplement)

2. Do you supply any food to the center for the participant's meals due to medical or religious reasons?

If Yes, please list foods supplied:

3. Signature and Parent/Guardian Information:

Parent/Guardian Signature _____

Date (Parents date form) _____

Print Name: _____

Home Telephone Number: _____

Work Telephone Number: _____

Address: _____

City: _____

State: _____

Zip Code: _____

For Sponsor Use Only.

Signature of Determining Official: _____

Date: _____

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If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer."

*7 CFR 226.15 (e)(2)

Date the participant withdrew: _____

Revised FY2014-2015
Child Care Income Application Letter

Dear Parent/Guardian:

Young children need healthy meals to learn. This letter is intended for parent or guardians of children enrolled at either a child care center or a family day care home. _____ offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care.

Please help us comply with the requirements of the CACFP by completing the attached income application as soon as possible. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

The completed form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of federal funding received by the center. If your household's income is equal to or less than the amounts indicated for your household's size on the chart below, the center will receive a higher level of reimbursement.

1. **Do I need to fill out an income application for each of my children in day care?** Complete and submit one CACFP income application form for all children in your household only if they are enrolled in the same center or home. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. Return the completed form to: _____.
2. **Who can get reduced priced meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, attached with this application.
3. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the center.
4. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you.
5. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. Once properly approved for free or reduced price benefits, whether through income or proof of benefits as supported by a current Supplemental Nutrition Assistance Program (SNAP) or K-TAP case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within eligibility standards.
6. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
7. **What if I have foster children?** In certain cases, foster children are eligible for free or reduced-price meals regardless of the income of the household with whom they reside. Fill out a separate application for each foster child in your care. However, if the foster children are siblings, each child may be listed on the same form. If this is a foster child, please indicate with a check mark on the application. Enter the foster child(ren's) personal use income (print "0" if the child has no income). Complete the form by proceeding to Part 4 and Part 5.
8. **The Kinship Care Program** operates under similar guidelines as that of foster care but the children are placed with family members. Under the Kinship Care Program, the state has custody of the child(ren) until permanent placement takes place (about 2 years later).
9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, nation origin, sex, age or disability.

If you have questions or need help, call _____ at _____.

Income Guidelines for Reduced Price Meals Effective July 1, 2014-June 30, 2015		
Family Size	Reduced Price Meals	
	Monthly	Yearly
1	\$1,800	\$21,590
2	\$2,426	\$29,101
3	\$3,051	\$36,612
4	\$3,677	\$44,123
5	\$4,303	\$51,634
6	\$4,929	\$59,145
7	\$5,555	\$66,656
8	\$6,181	\$74,167
For each additional family member add:	+\$626	+\$7,511

PRIVACY ACT STATEMENT: 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 the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: "The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.inlacc@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer."

Sponsor Representative

Phone Number

If you have questions about the CACFP and its administration, you may contact Deanna Tackett, Division Director at 502/564-5625 or at the following address: School and Community Nutrition, Kentucky Department of Education, 500 Mero Street, Frankfort, KY 40601.