Enrollment Application

Community Family Development

Phone: 845-471-5301♦ Fax 845-471-6992

Child Information

Child's Name:	**Child's Date Of Birth:** **Child's Sex: Male or Female**
Allergies/Restrictions:	**Child's Address:** _____ **Street/Apt #** _____ **City, State, Zip**
Child's Schedule: (*Circle One)* **(Full Time/Part Time) *Check Days Child Will Attend:*** **__Mon ___Tues ____Weds ___Thurs___Fri**	**Child's Typical Drop Off Time _____** **Child's Typical Pick Up Time _____** **Meals Eaten At The Center** **__Breakfast _____Lunch _____PM Snack**

Parent/Guardian Information:

Parent's Name	**Parent's Address (if different from child)**
Parent's Phone #	**Parent's Email:**
Relationship to the child:	
<u>Second Parent/Guardian</u>	
Parent's Name	**Parent's Address:**
Parent's Phone #	**Parent's Email:**

PARENT AUTHORIZATION FOR RELEASE

I authorize the following people to pick up my child:

Authorized Pick Up & Emergency Contacts

Authorized Person's Name (First, Last)	Phone #	Relationship	Authorized for Pick Up

NO CHILD WILL BE PERMITTED TO LEAVE THE CENTER WITH AN <u>UNAUTHORIZED</u> PERSON. ID IS REQUIRED AT THE TIME OF PICKUP.

Signed: _____ Relationship: _____Date:_____

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Financial Agreement/Tuition Contract

This tuition and fee contract is between Community Family Development and the below listed responsible party. Signing this contract guarantees both payment on the part of the parent or guardian and placement in Community Family Development. Payment is expected at the end of each week. All fees are expected to be paid on a weekly basis. Failure to submit weekly payments for (2) two consecutive weeks will result in removal from the program. _____*init*

Tuition Rates as of 2022

My Weekly Tuition Fee is $_____. I agree to pay the such amount on a weekly basis ____*Init*

	Infants	Toddlers	Preschool & Pre-K
Half Day	**$50**	**$47**	**$43**
Daily	**$75**	**$71**	**$65**
Weekly	**$336**	**$314**	**$293**

School Age Rates

Type of Rate	AM Care (7am-830am)	PM Care (3-530pm)	AM & PM Care (7-830am/ 3-530pm)	Full Day Care for PCSD closure
Daily	$19.50	$19.50	$39	$55
Weekly	$97.50	$97.50	$195	$258

My employer:
Company: _____Telephone:_____

Supervisor: _____ Address_____

DCFS Families Only:

As a parent using the services of the Community Family Development I agree to the following.

Please initial the following:

_____ - attend my approved DSS work activity
_____ - perform my approved DSS job search activity
____ - I authorize Community Family Development permission to contact my place of employment for the purpose of verify my work attendance. I also understand that Community Family Development will call my employer any time it deems necessary.
_____ - I agree and understand that I am responsible for all charges not paid by DSS.
_____ - I assume responsibility for all charges not paid by DSS after my child/children are not enrolled in the center.
_____ - I understand and acknowledge that the center will forward upon disenrollment my account to an outside collection agency in the event I have a remaining unpaid balance. All actions within the confines of the law will be use to collect payment to Community Family Development.
_____ - I understand and agree to notify DSS and Community Family Development within 48 hours of any changes to my: household composition, income, employment hours, earnings and changes to my DSS approved activity.

DSS = Dutchess County Department of Community & Family Services

DCFS Recipients Only

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Permissions

FIELD TRIP PERMISSION

My child, _____

- ☐ Does have permission to go on walks, trips, and excursions as arranged by the Center
- ☐ Does not have permission to go on walks, trips, and excursions as arranged by the Center.

PHOTO PERMISSION

Pursuant to law, we will not release any photos/images without prior written consent from you as a parent or guardian. Community Family Development is requesting permission from you to allow your child to be photographed while attending the Center and for the pictures to be used in the following manner.

Check ONE of the following choices:

___Permission to use photo / image on our website, in brochures, in classrooms, etc. for marketing purposes.

___ Permission to use photo / image in our classroom only

___I DO NOT WISH TO HAVE MY CHILD PHOTOGRAPHED FOR ANY PURPOSE.

Authorization for Emergency Medical Treatment

As the parent / guardian of: _____, I hereby give permission for my child to be transported by ambulance in case of a health emergency to the hospital.

Hospital Preference: _____Home Phone: _____ Cell Phone: _____

Allergies/Medication/Restrictions:_____

PARENT HANDBOOK ACKNOWLEDGEMENT

I have viewed the parent handbook, located at www.communityfamilydevelopment.org/forms

Demographic Survey:

Please visit the link to complete our demographic survey https://forms.gle/XwmGmLkZhKqTydMs8

My signature affirms that I have acknowledged all of the above permissions and agree to abide by the policies stated within the handbook.

_____ _____

Signature Date

Community Family Development
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Authorization to Allow Application of Basic Care Items During Hours of Daycare

Basic Care Items Allowed:

Sunscreen Lotion	Petroleum Jelly / Vaseline	Desitin or Zinc Based Ointment
Petroleum Based Chopsticks	A & D Ointment	Lalolin Based Lotions

INSTRUCTIONS:

Child's Name: _____

Parent's Name: _____

Item of Basic Care Item: _____

Application (Where & How To Apply): _____

Start & Stop Date: _____

Times: _____

_____ _____
Parent's Signature Director's Signature

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER ☐☐☐☐ DATE _____

USDA is an equal opportunity provider and employer.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. 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 form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR CENTERS AND SPONSORS

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid.*

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2014 is valid until May 31, 2015.